

Robert S. Salmans, DDS, Inc.
New Patient Profile

Patient Name/Date: _____

We want to make your experience in our office as comfortable as possible.

Please complete this profile, so that we may address any concerns you may have.

1. Is keeping your natural teeth important to you? **YES** or **NO**

I would like to keep my natural teeth until _____

2. Please circle the level of fear you have, regarding dental treatment
(1 having no fear and 10 being most fearful)

1 2 3 4 5 6 7 8 9 10

3. I would like to know more about sedation medication to maximize my comfort during my dental visits.

YES or **NO**

4. Are you pleased with the appearance of your teeth when you smile? **YES** or **NO**
If no, what would you like to change? Circle all that apply.

- Breath is bad
- Don't like the shape of my teeth
- Want whiter teeth
- Old dental treatment needs replaced
- Bite isn't right
- Want straighter teeth
- Want white fillings to replace mercury fillings
- *Anything else?* _____

5. When we review any treatment needs with you would you like us to be

Very detailed or ***Just give you the big picture of what needs to be done***

6. List and explain anything else that is a concern or objection for you.
