NORTH HILLS PERIODONTICS, LLC

Charu S. Chandra, D.M.D., M.D.S.

222 South Clay Street, Zelienople, PA 16063 • 220 N. Main Street, Suite 1, Butler, PA 16001

724-453-0234 • infor@northhillsperio.com

WE'RE CONCERNED ABOUT YOU

We understand that you are unique and have unique concerns. So that we can provide you with the best possible care, check off the statements that apply to you.

Name: ____

	(Yes)	(No)
1. I am nervous being in a dental chair.	_____	_____
2. I have had a bad experience in a dental office.	_____	_____
3. I sometimes get dizzy lying back in a dental chair.	_____	_____
4. I have had difficulty with gagging or suctioning.	_____	_____
5. I would like to take breaks during long appointments.	_____	_____
6. My teeth or gums are very sensitive.	_____	_____
7. I don't like dental noises such as drilling or suctioning.	_____	_____
8. I haven't been to the dentist in a long time and am afraid of what you might say about my teeth.	_____	_____
9. I am not comfortable being lectured to by doctors.	_____	_____
10. I will need to relay what you tell me to spouse or someone else.	_____	_____
11. I don't like shots (or have had bad experience with them).	_____	_____
12. I have concerns about the appearance of my teeth or smile.	_____	_____
13. I have concerns about, eating, chewing, or bad breath.	_____	_____
14. I have concerns about insurance or finances.	_____	_____
15. I have another question or concern. (Please write it below.)	_____	_____

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Thank you for sharing your thoughts.

Dr. Chandra & Staff