

GLEN PERIODONTICS & IMPLANT DENTISTRY
VLADIMIR REZNIKOV, D.D.S.

WE ARE CONCERNED ABOUT YOU

We understand that you are unique and have unique concerns. So that we can provide you with the best possible care, please 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 have concerns about appointment scheduling	_____	_____
9. I would like extra care to relieve pain	_____	_____
10. In the event that you need treatment, is there another person (e.g. spouse, parent, etc.) who is involved in decisions regarding your healthcare and/or your financial decisions?	_____	_____
11. I don't like shots (or have had a bad experience with them)	_____	_____
12. I have concerns about the appearance of my teeth or smile	_____	_____
13. I have concerns about losing my teeth	_____	_____
14. I have concerns about insurance or finance	_____	_____
15. I have another questions or concerns: _____		

Thank you for giving us your thoughts.
Dr. Reznikov & Staff