

William J. Carter, D.D.S., M.S.
Periodontics & Dental Implants

WE'RE CONCERNED ABOUT YOU

We understand that you are unique and have unique concerns. You may also have special needs for treatment given your medical history. So that we can provide you with the best possible care, please check off the statements that apply to you. Sincerely, William J. Carter, DDS, MS

Name: _____ **Date:** _____

| | 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 don't like shots (or have had a bad experience with them). | _____ | _____ |
| 9. I would like extra care to relieve pain. | _____ | _____ |
| 10. I am not comfortable being lectured to by doctors. | _____ | _____ |
| 11. I will need to relay what you tell me to my spouse or another. | _____ | _____ |
| 12. I have concerns about appointment scheduling. | _____ | _____ |
| 13. I have concerns about the appearance of my teeth or smile. | _____ | _____ |
| 14. I have concerns about eating, chewing, or bad breath. | _____ | _____ |
| 15. I have concerns about insurance or finances. | _____ | _____ |
| 16. I have another question or concern. (Please write it below.) | _____ | _____ |

17. Please check off if you (or a family member) have any history of the following:

| | Yourself | Parents | Grandparents |
|------------------------|----------|---------|--------------|
| A. Alzheimer's Disease | _____ | _____ | _____ |
| B. Blood Cancer | _____ | _____ | _____ |
| C. Diabetes | _____ | _____ | _____ |
| D. Heart Attack | _____ | _____ | _____ |
| E. Heart Disease | _____ | _____ | _____ |
| F. Kidney Cancer | _____ | _____ | _____ |
| G. Lung Cancer | _____ | _____ | _____ |
| H. Lung Disease | _____ | _____ | _____ |

| | Yourself | Parents | Grandparents |
|-------------------------|----------|---------|--------------|
| I. Obesity | _____ | _____ | _____ |
| J. Osteoporosis | _____ | _____ | _____ |
| K. Pancreatic Cancer | _____ | _____ | _____ |
| L. Premature Childbirth | _____ | _____ | _____ |
| M. Stroke | _____ | _____ | _____ |
| N. Tongue Cancer | _____ | _____ | _____ |
| O. Other Cancers | _____ | _____ | _____ |
| P. Tooth Loss/Dentures | _____ | _____ | _____ |