Michael S. Schroer, DDS, PLC
Periodontics & Dental Implants
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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, Michael S. Schroer, DDS

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*		*Yourself*	*Parents*	*Grandparents*
A. Alzheimer's Disease	____	____	____	*I. Obesity*	____	____	____
B. Blood Cancer	____	____	____	*J. Osteoporosis*	____	____	____
C. Diabetes	____	____	____	*K. Pancreatic Cancer*	____	____	____
D. Heart Attack	____	____	____	*L. Premature Childbirth*	____	____	____
E. Heart Disease	____	____	____	*M. Stroke*	____	____	____
F. Kidney Cancer	____	____	____	*N. Tongue Cancer*	____	____	____
G. Lung Cancer	____	____	____	*O. Other Cancers*	____	____	____
H. Lung Disease	____	____	____	*P. Tooth Loss/Dentures*	____	____	____