



WASHINGTON CENTER
for Cosmetic Dentistry

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PATIENT DENTAL SURVEY

We are striving to be the best! And we value your opinion and ask that you complete this questionnaire to help us achieve our goal.

Please be as detailed as possible.

1) Can you give us some information about your past Dental experiences?

2) How would you describe the Perfect Dentist?

3) What would you most want to achieve from your dental care?

4) What would be the most convenient days/hours for you to have your dental visit?

Name: _____

Date: _____