

# Domestic Violence Dental Care Program (DVDCP) Satisfaction Interview

Date: \_\_\_\_\_ Your Name (OPTIONAL): \_\_\_\_\_

Name of Your Primary (General) DENTIST: \_\_\_\_\_

Names of Specialists Visited (If Any): \_\_\_\_\_

\_\_\_\_\_

In order to refine our program to meet the needs of our participants, we ask you to evaluate the program on this form. Please circle your answers using a 1 for least effective and a 5 for most effective. **Please make written comments throughout!**

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**Would you recommend the DVDCP to others?**

Yes

No

**How would you rate the overall program?**

1

2

3

4

5

N/A

Comments: \_\_\_\_\_

\_\_\_\_\_

**How did you learn about the program? How did you apply?**

Comments: \_\_\_\_\_

\_\_\_\_\_

**What was your primary reason for seeking dental treatment?** (check all that apply)

- Pain
- Dental function impaired (*for example: could not chew or bite, difficulty speaking*)
- Appearance issue

**My dental issues were a result of...**

- Trauma resulting from domestic violence attack (*i.e. knocked out/chipped teeth or damaged dentures*)
- Issues resulting from neglect (*i.e. gum disease, dental decay*)
- Both

**How long did you wait after applying to the program to be placed with a dental office?**

Comments: \_\_\_\_\_

\_\_\_\_\_

**How helpful was the information in your DVDCP/Dental Health Orientation Packet?**

1                      2                      3                      4                      5                      N/A

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**How clear was the dentist/office in explaining the treatment you received?**

1                      2                      3                      4                      5                      N/A

**How long did it take to complete the treatment you received? \_\_\_\_\_**

**During the span of your treatment, how many times did you visit a dentist’s office (Mark One)**

- 1 time..... 1
- 2 times ..... 2
- 3 to 5 times..... 3
- 6 or more times..... 4

**How do you rate... (Mark One Box on Each Line)**

	Very Poor (F)	Poor (D)	Fair (C)	Good (B)	Very Good (B+)	Excellent (A)	The Best (A+)	Does Not Apply
Convenience of the location where you received care								
Quality of Treatment you received								
Answers to your questions								
Dental team’s effort to make your visit comfortable and pleasant								
Quality of examinations you received								
Ease of scheduling appointments								
Ease of reaching the office by phone when you have problems								
Reassurance and support offered to you by doctors and staff								

**On a scale of 1 to 10, how do you rate the importance of dental health in your day-to-day life? (1 = not important; 10 =most important)**

1      2      3      4      5      6      7      8      9      10

**On a scale of 1 to 10, how do you rate the importance of a healthy smile in your overall self-esteem? (1 = not important; 10 =most important)**

1      2      3      4      5      6      7      8      9      10

**In your own words, please describe the need for this type of program and what the care provided has meant to you:** (if you run out of space, please use a separate sheet)

**OTHER COMMENTS:**

**OPTIONAL:**

We ask your permission to contact you within the next 6 to 12 months with follow-up questions on your dental care, your experience in the program and/or any personal achievement of goals resulting from enhanced oral health/appearance (for example, a new job, increased self-esteem, etc...). If you will allow us to contact you, please fill out the information below.

Please contact me:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**THANK YOU!!!**  
**Please return this form to**  
**your advocate or:**

Mail to: Michelle Cunningham  
MDDS/MDDF  
3690 South Yosemite Street, Suite 200,  
Denver, CO 80237

Fax to: (303) 488-0177

Email your comments to: [pr@mddsdentist.com](mailto:pr@mddsdentist.com)