4-2023

Analyzing the Patient-Provider Relationship and Assessing Shortages in Oral Healthcare in Arenac County, Michigan

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HNR 499: Senior Project

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April 20, 2023

Abstract

The purpose of this prospective study will be to assess the patient-provider relationship in Arenac County, Michigan, analyze barriers to treatment for rural patients, and develop a meaningful plan to improve upon these categories. The intended outcomes of this study will be the development of a resource for rural oral healthcare providers to better understand and treat the needs of their patients based on knowledge from beyond the chairside, as well as the development of an easily repeatable model for patient-provider analysis. Furthermore, the questionnaires and data collected from this could assist in informing governmental or non-governmental organizations in identifying where gaps in treatments lie for rural communities. It was revealed from the provider questionnaire that the primary barriers to oral healthcare for this population are financial issues and a lack of providers. Several solutions were proposed ranging from incentivizing new practices in the region to mobile dental clinics, but the single most effective measure would be to improve patient oral healthcare education to reduce the risk of preventable dental disease.

Introduction and Background

In the United States, there are currently seventy million people living in dental Health Professional Shortage Areas (HPSA).[1] According to the United States Health Resources and Services Administration, an HPSA is defined as geographic areas, populations, or facilities with a shortage of healthcare providers, and can be in the categories of primary, dental, or mental healthcare. [2] To fulfill these national shortages,

there is a need for 11,909 dentists.[1] In Michigan alone, there are 55 counties whose whole area is in shortage and 17 counties with partial shortages. [3] Arenac County falls under the former. Located in the Great Lakes Bay Region, Arenac County has a population of approximately 15,000 people as of July 2021 over an area of 361 square miles of land. The population is relatively nondiverse racially, with 95.7% of the population identifying as Caucasian. Furthermore, only 14.3% of the population holds a bachelor's degree, as compared to the national average of the United States at 34.98%.[4] Lastly, 14.9% of the population lives in poverty, which is 3.0% higher than the poverty rates for urban areas. [4]

Arenac County was selected as the focus of this study for a variety of reasons. First, the community is one I am familiar with as I grew up only twenty miles South of here, and both of my parents have practiced there as optometrists for over 20 years. Next, I completed the vast majority of the shadowing requirements for dental school in Standish, MI with Dr. Andrew R. Dwan, so I have some degree of familiarity with the patient base he sees and some of the surface-level problems faced in providing treatment. Finally, it is a region I would like to return to practice dentistry upon my graduation from the University of Michigan School of Dentistry in 2027, and I saw this project as a unique opportunity to become as informed as possible in making such important decisions in my future. I am especially interested in returning due to the underserved nature of the community, as I believe it would result in a mutually beneficial relationship where I could have a profound impact on the community and practice my skills as a new dentist seeking experience. Currently, there are only two dental

providers in the county, with a population-to-provider ratio of 7,500 to 1.[5] Nationally, the average ratio of population to dentists is 1,643 to 1.[6]

Oral healthcare in rural areas faces numerous challenges. The aforementioned shortage of dental professionals is perhaps the greatest issue, along with the increased poverty rates. Additional reported barriers to improved oral health include a lack of childcare, lack of public transportation, greater distances to travel for treatment, insufficient water fluoridation, and lack of proper patient education. As a result of this, rural patients are more likely to have unmet oral healthcare needs.[7] Thus, they are at greater risk of dental cavities, gum disease, and other serious dental diseases which can hinder daily activities such as eating or communicating. Children living in rural areas in particular are at a greater risk for cavities, with one study finding that 62.9% of these children have untreated dental caries as opposed to 37.1% of rural children with untreated dental caries, a statistically significant margin ($p < 0.001$).[8] Beyond this, untreated oral diseases become problematic for the holistic health of the patient, as poor oral health has been found to be linked to chronic diseases such as Alzheimer's disease, diabetes, and several forms of cancer.[9] Untreated cavities alone have the potential to cause root infections, which can progress to systemic infections.[10] As mentioned above, rural Michigan has an abundance of rural communities with limited access to oral healthcare; therefore, their populations are at a higher risk of these diseases.

Methodology

First, I conducted background research on rural dentistry, including how it differs from urban or suburban settings as well as generalized issues faced in rural oral healthcare. Additionally, I gathered information on Arenac County, Michigan, primarily concerning demographics. From this, I interviewed Dr. Andrew R. Dwan, a general dentist who has been practicing in Standish for over 25 years. This interview was performed through a questionnaire (Appendix I), and featured questions directed toward his background, experience working in a rural setting, some of the problems he faces in providing care, and some areas of his relationship with his patient base he would like to expand upon. This questionnaire is designed to be used for any given dentist, with some minor tweaks to questions based on location or individual experience. From this, I developed a questionnaire for the patients of this provider (Appendix III). This questionnaire will also have questions concerning perceived barriers to treatment as well as questions concerning their side of the patient-provider relationship. This insight, or predicted insights, will then be used in conjunction with the background research to generate potential solutions for these issues.

Dentist Questionnaire and Responses

The questionnaire was given to Dr. Dwan to fill out at his own pace without an established time limit. It took approximately 14 days to complete due to additional responsibilities. Given the responsibilities of a dentist, especially as a practice owner, it

was determined that not enforcing time constraints allowed for the most thorough response. The completed questionnaire is included in Appendix II for reference.

Upon completion of the questionnaire, it was clear that Dr. Dwan's years of experience had left him with a firm understanding of his patient base, both qualitatively and quantitatively. In his self-rankings, he strongly agreed that he has both a strong relationship with his patients and that there is a high level of trust from his patients in him and his staff. It can be inferred that because of this, he feels he does not have to sell or push treatments onto his patients. It is worth noting though, that he identified that a lack of perceived need for treatment and lack of compliance with treatment planning poses challenges. Patients, particularly those with financial struggles, appear to be more likely to refuse treatment or opt for nonideal treatments due to cost. I was particularly compelled by Dr. Dwan's perspective gained from his work in Guatemala and how that shapes his opinion on this topic. While he may have a treatment plan his office views as ideal, the patient may not see it in the same light. As a practitioner, one is tasked with educating their patients on their options, but ultimately, the choice is entrusted to the patient based on what they believe is the best choice for their specific circumstance and one must respect that. From here, the practitioner must faithfully execute this plan to the best of their ability. Outside of the office, it is the patient's responsibility to maintain their oral health. With this, Dr. Dwan made it clear that the investment in early and proper treatment is well worth it. When left untreated, oral disease will progress leading to increased damage as well as more extensive treatment which will tend to lead to a heavier financial burden as well as increased discomfort, a common fear of those seeking dental treatment.

Another key takeaway was the diversity in his patient base. Despite not being as racially diverse as other regions, there is a great socioeconomic diversity. As identified in the background, the majority of the population does not hold a bachelor's degree and would be considered members of the working class, but the office also treats patients with professional degrees and a wide range of those in between. With this, he mentioned it is imperative to approach each patient encounter at an individual level. A wide variety of factors impact the dynamic of the patient-provider relationship from education, beliefs, biases, and expectations. By analyzing these and tailoring one's interaction to the individual, a provider is able to improve communication which will make the patient more comfortable and improve their understanding of the situation.

The most profound conclusion from this questionnaire was the confirmation of the lack of access to oral healthcare, which comes from various factors. First, there lies the economic barrier. With nearly 15% of the population below the poverty line, the financial burden of dental treatment is not to be understated and can pose legitimate concerns for patients, as some may feel they have to choose between paying for treatment and other essential needs. Travel times could pose a barrier for some patients living in more remote areas as patients must travel to population centers to receive treatment. The rural environment makes travel even more difficult, especially for those who are socioeconomically disadvantaged as there is a lack of public transportation in this region. Finally, there comes the high patient-provider ratio. With the aforementioned population-to-provider ratio of 7,500 to 1, there simply are not enough dentists to see patients in a timely manner. Longer wait times could lead to a patient's condition worsening, further exacerbating financial burdens and pain associated with it. Dr. Dawn

mentioned that there is a need for Arenac County to attract more providers, whether that be by improving its image or by incentivizing practicing in the region.

Patient Questionnaire and Expected Responses

The use of Google Forms was chosen as it was determined to be an easily accessible method of completing the questionnaire, so long as the individual has access to a smart device or computer. Furthermore, it also allows for a wide distribution of the form. Potential ways to get the questionnaire to the patient include follow-up emails after an appointment, a QR code on a postcard, QR codes posted in the waiting room of the office, as well as a link to the form on the office's website. As mentioned above, the provider questionnaire was used to direct the formation of the patient questionnaire. The patient questionnaire was kept shorter than the provider questionnaire, with the intention of increasing engagement with the survey. In an effort to further reduce the time to complete, the vast majority of questions were formatted as multiple choice or in a Likert scale, with four optional short answer responses.

Many questions were designed to be the same as those used in the provider questionnaire but reworded to reflect the patient side of the patient-provider relationship. The patient questionnaire was not implemented in this project. The results would be expected to be consistent with Dr. Dwan's insight as he has a deep level of understanding of his patient base due to his extensive experience with them over the course of 25 years. If this questionnaire were to be implemented, any new insights would be used to help develop solutions to the lack of treatment.

. Using the anecdotal information from the provider questionnaire as well as background information regarding the demographics of Arenac County, several predictions were made. To start, the predicted primary concern reported by patients when it came to oral healthcare would be the cost of treatment. Even for those with dental insurance, there are often gaps in coverage which can lead to unexpected financial burdens. Next, dental anxiety would likely play a role in patients' comfortability in the office and willingness to seek out dental care. With 36% of people having a fear of dental treatment and 12% of people having extreme fear, dental-related anxiety could be the difference between a patient seeking treatment or allowing their oral disease to progress. Additionally, it would be expected that the patients might express the need to travel greater distances to reach care as a barrier to treatment. At the most extreme, those living in Arenac County would have to travel 26 miles to reach Standish, where the only two dentists in the county practice. Finally, it would be expected that the patients of Dr. Dwan would reciprocate the belief that their relationship is strong and that they hold a high level of trust in his practice. He is well-known as a leader in the community, well-respected as a doctor, and a skilled communicator, all of which I have been able to experience firsthand through the 150 hours I spent shadowing him.

Reflection

With the insight from this study overwhelmingly indicating that patients' financial struggles as well as a lack of providers in the region negatively impact the oral health of the region, it is imperative to address these strongly when creating a plan of action. First and foremost, one of the most impactful and cost-effective ways to combat this

would be through improved education regarding dental hygiene. With the vast majority of oral diseases being preventable, improving oral hygiene at home has the potential to reduce the prevalence of periodontitis, dental caries, and their subsequent complications.[11] This would reduce the financial burden on patients as well. Patient education could be expanded in a variety of means including visits from dentists or dental hygienists to schools to discuss proper oral healthcare and diet at home, providing informational resources to parents regarding their children's oral health, or creating an easily accessible website with a database on oral disease and management. Essentially by expanding education efforts and with patient compliance, the amount of preventable oral disease in the community would be reduced.

Non-governmental organizations could play a role in increasing the accessibility of care in this region as well. One possibility to supplement education would be to provide low-income families with free oral care products such as toothbrushes, toothpaste, and floss. In doing so, they would remove one aspect of the financial barrier. Additionally, there is the possibility of providing gap coverage for those enrolled in state-funded insurance such as Medicare and Medicaid. Finally, an NGO could hire a dentist and a dental assistant to provide care through the use of a mobile dental clinic. In doing so, they could reduce the need for patients to travel by taking the clinic to directly smaller population centers in more isolated regions. While a small town of a few hundred people might not have an adequate amount of potential patients to make opening a practice financially feasible, it would be likely a sufficient amount for a short-term clinic. After several days, the small team could then travel to the next rural community and continue the process. The mobile dental clinic has been proven to be

effective in providing high-quality care to patients while maintaining financial feasibility in a study performed in rural Montana. [12] Another study identified mobile dental clinics as being especially useful in treating certain marginalized communities such as low-income families, the homeless, those with mental illnesses, elderly individuals, and those with physical disabilities.[13] I believe this model could also be applied in Arenac County, although it is likely that this mobile clinic would need to serve neighboring counties as well to have a high enough volume of patients.

Another way in which the oral health of Arenac County could be improved would be through better allowing patients to utilize their insurance plans. It has been found that particularly among rural Medicaid patients, utilization rates of dental insurance were lower than that of urban patients, even when considering that 51% of rural dentists participate in Medicaid as opposed to only 32% of urban dentists. [7] The same study determined that the most important factor in patients' utilization of their insurance was the overall proportion of dentists to patients, which was lower in rural areas. The authors argued that in order to improve access to treatment, policymakers must focus on garnering and maintaining a high volume of rural dentists. Aside from the potential NGO involvement suggested above, policymakers should consider identifying ways to incentivize dentists practicing in rural communities. In order to do so, the government could offer cash grants for those seeking to develop a start-up rural practice, offer tax credits to dentists operating in underserved communities, and by offering more competitive salaries to dentists working in rural Federally Qualified Healthcare Centers.

Conclusion

With this project, it is my hope that I have been able to better identify and increase understanding of the conditions that the patients of Arenac County face, first through data analytics as well as first-hand experience through the patient-provider relationship, and by better understanding these conditions, developed a tailored plan to better serve this population. Furthermore, the development of the provider questionnaire as well as the patient questionnaire could serve as a resource or model at the governmental level or by a non-governmental organization to better analyze the needs of a given area and formulate a plan of action to address these needs. The initial use of metrics is important, but it is my firm belief that first-hand experiences of patients and providers in the area will produce the most effective response based on the unique problems a given community faces. This project should serve as a proof of concept and act as a simple, highly repeatable analytical tool even if used for individual practices to better analyze their relationship with their patient base.

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Appendix I

Provider Questionnaire

Q1. What inspired you to become a dentist?
A1.

Q2. Could you describe your pathway to dentistry?
A2.

Q3. How many years have you been practicing?
A3.

Q4. Have you had any experience treating patients in an urban area?
A4.

Q5. What drew you to practice in Standish, MI?
A5.

Q6. (If applicable) How do patient interactions differ between urban and rural patients?
A6.

Q7. What types of patients do you see? (ie. socioeconomic status, level of education, age, etc.)
A7.

Q8. What insurance(s) do you see the highest volume of patients of?
A8.

Q9. How does the oral health of your patient base compare to the average person?
A9.

Q10. Are most of their required treatments preventable? Could their oral health benefit from improved patient education or proper execution of recommended hygiene?

A10.

Q11. How would you describe your relationship with your patient base?
A10.

Q12. What aspects of your patient-provider relationship would you like to improve?
A12.

Q13. What are some barriers to treatment that patients express to you? What are some perceived barriers from your end?
A13.

Q14. What are some of the biggest problems you face in providing treatment to your patients?
A14.

Q15. Would you say the population of Standish and Arenac County is underserved? If yes, in what ways could this be addressed?
A15.

Q16. Are there any topics or services you find particularly difficult to communicate to patients?
A16.

Q17. What do you wish you knew more about in regard to your patients?
A17.

Q18. What do you wish your patients understood more about you or your office?
A18.

Q19. You have done work in Guatemala for a number of years, has your experience there changed how you view or treat your patients in Standish?
A19.

Q20. What advice would you have for new dentists looking to practice in rural communities?
A20.

Q21. Going back to the start of your career, would you still have decided to practice in Standish, MI? Why or why not?
A21.

For the Likert Scale Below, please indicate your answer with an X in the box you feel best represents your feelings.

	Strongly Disagree	Partially Disagree	Neutral	Partially Agree	Strongly Agree
Q22. I have a strong relationship with my patients					
Q23. My patients trust my staff and me					
Q24. I feel that I have to "sell" treatments to patients					
Q25. My patients lack the resources to complete treatment plans					
Q26. My patients face barriers to treatment due to their rural environment (distance, lack of providers, etc.)					

Additional Comments:
-

Appendix II

Provider Questionnaire

Q1. What inspired you to become a dentist?
A1. I assumed I would go into one of the health professions. I had applications out to medical and dental programs. When my uncle planned to retire I decided to go into dentistry and assume his practice which was started by my grandfather.

Q2. Could you describe your pathway to dentistry?
A2. As I finished my studies at MSU I interviewed at both medical and dental programs. I decided on dentistry at the University of Michigan and chose to become a General Practioner.

Q3. How many years have you been practicing?
A3. I have been practicing for 26 years.

Q4. Have you had any experience treating patients in an urban area?
A4. I have not had any experience in urban settings

Q5. What drew you to practice in Standish, MI?
A5. I looked for practices in Mid and Northern Michigan. I found a dentist who was looking to retire. From an economic standpoint, it made sense, I was in debt and ready to work.

Q6. (If applicable) How do patient interactions differ between urban and rural patients?
A6. N/A

Q7. What types of patients do you see? (ie. socioeconomic status, level of education, age, etc.)
A7. I work in a small town, therefore I treat patients from all levels of socioeconomic society. There is no homogeny in town, I treat the affluent and the poor, the doctors and the dropouts.

Q8. What insurance(s) do you see the highest volume of patients of?

A8. Delta Dental is our largest insurance base.

Q9. How does the oral health of your patient base compare to the average person?
A9. My patients are the "average person" However my average differs from more homogenous locations. 14.3% have a bachelor's degree, and 14.9% live below the poverty line. I see many patients from lower socioeconomic groups who have higher rates of disease, both previous and untreated.

Q10. Are most of their required treatments preventable? Could their oral health benefit from improved patient education or proper execution of recommended hygiene?
A10. Most dental problems are preventable. Education and compliance with diet and oral hygiene practices could alleviate many problems.

Q11. How would you describe your relationship with your patient base?
A11. I feel most of my patients trust me and feel I am working in their best interests. After years of seeing families, they seem like friends.

Q12. What aspects of your patient-provider relationship would you like to improve?
A12. Some patients fear the dentist due to preconceived notions and previous poor experiences. I work to improve their experience to help them through the appointment.

Q13. What are some barriers to treatment that patients express to you? What are some perceived barriers from your end?
A13. Economic issues and fear of pain are frequent barriers my patients inform me of. Economics is an issue, however, the earlier the problem is treated it will be less expensive and less extensive requiring less treatment.

Q14. What are some of the biggest problems you face in providing treatment to your patients?
A14. Fear, lack of resources, and lack of perceived need for treatment lead to postponement.

Q15. Would you say the population of Standish and Arenac County is underserved? If yes, in what ways could this be addressed?
A15. Yes, the patient-to-provider ratio is high. This leads to my schedule being full which makes patients wait or seek treatment elsewhere. Arenac County needs to appear more

attractive to providers so they can understand the benefits of working in this community and to improve its image.

Q16. Are there any topics or services you find particularly difficult to communicate to patients?
A16. I think communication is good, but compliance is challenging.

Q17. What do you wish you knew more about in regard to your patients?
A17. I try to understand their beliefs, expectations, and bias to determine the barriers to their treatment.

Q18. What do you wish your patients understood more about you or your office?
A18. We try to keep them healthy in the most painless and cost-effective manner possible. We are not trying to take advantage of them.

Q19. You have done work in Guatemala for a number of years, has your experience there changed how you view or treat your patients in Standish?
A19. Yes. One way it has changed my thinking is to realize that their desires might be for nonideal treatment. It is my responsibility to educate and inform them, but at the end of the day it is their body and I should take their unique situation into account.

Q20. What advice would you have for new dentists looking to practice in rural communities?
A20. Talk to practitioners. There is opportunity economically as well as socially if people can get past preconceived notions.

Q21. Going back to the start of your career, would you still have decided to practice in Standish, MI? Why or why not?
A21. Like many things in life, in hindsight, one can think how life may have been different. I could have been an academic dental researcher or multiple practice owner in a big city. However, I am not regretful one ounce. It has provided me the freedom to work for myself, pushed me to expand the scope of my services due to the distance of specialists, provided me with an economical lifestyle I had dreamed of, and allowed me to be an integral part of our community.

For the Likert Scale Below, please indicate your answer with an X in the box you feel best represents your feelings/opinions.

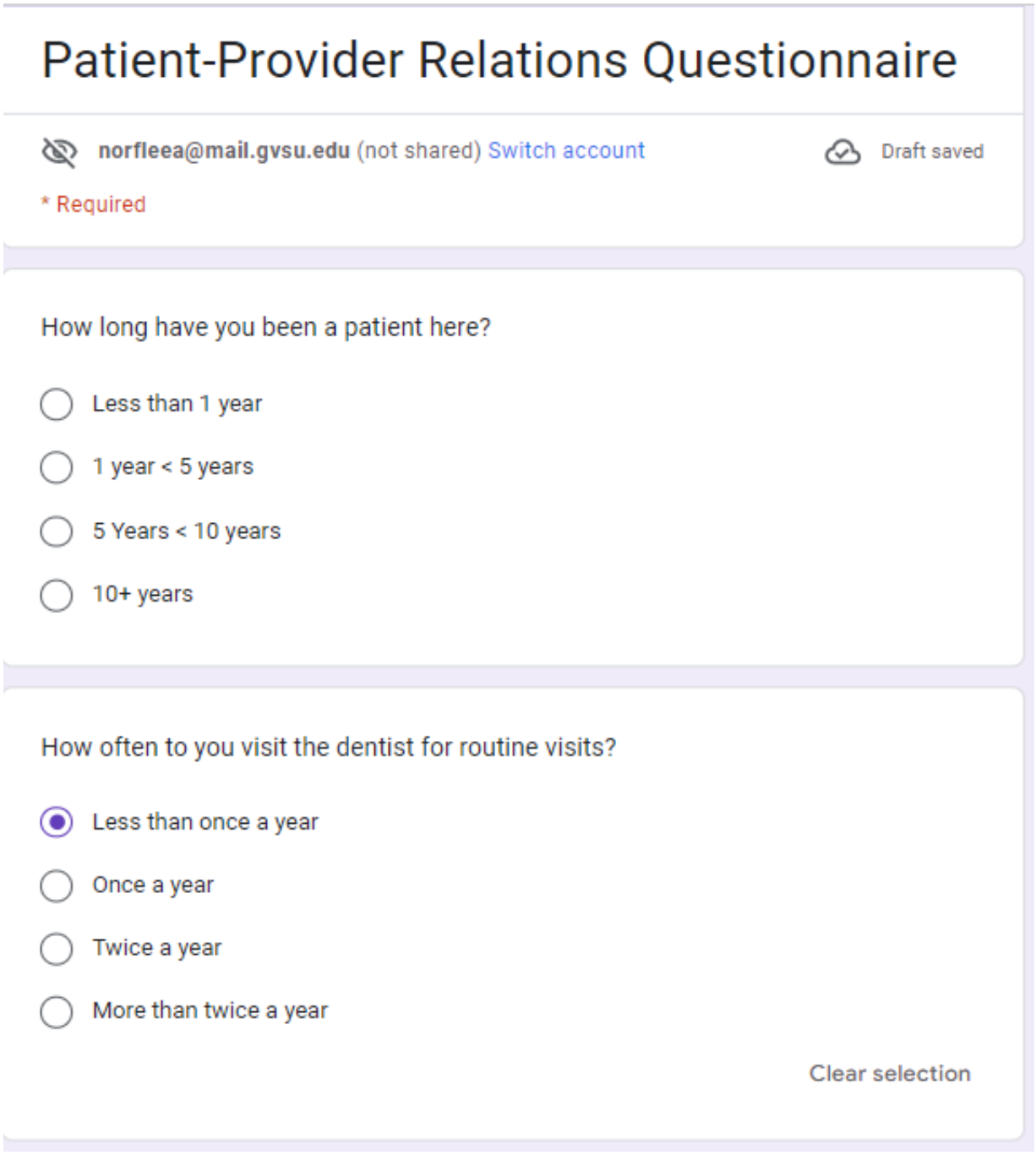
	Strongly Disagree	Partially Disagree	Neutral	Partially Agree	Strongly Agree
Q22. I have a strong relationship with my patients					X
Q23. My patients trust my staff and me					X
Q24. I feel that I have to "sell" treatments to patients			X		
Q25. My patients lack the resources to complete treatment plans					X
Q26. My patients face barriers to treatment due to their rural environment (distance, lack of providers, etc.)					X

Additional Comments:

-I feel Rural America has challenges that other communities have, but at an increased level than many others. Increased poverty and lower levels of education lead to higher levels of disease and a lower ability to afford treatment. Medicaid practices do not have enough practitioners and low reimbursement rates that make most practices unable to accept it. That being said, there are wonderful people who need treatment in these communities. Having practitioners in rural communities removes a barrier that would otherwise prevent treatment.

Appendix III

https://docs.google.com/forms/d/e/1FAIpQLScWz-ynOPcLFJJAY2OaFTPG5MvIEWt6qXicpMNUCZsPp1plFQ/viewform



Patient-Provider Relations Questionnaire

norfleea@mail.gvsu.edu (not shared) Switch account

Draft saved

* Required

How long have you been a patient here?

- Less than 1 year
- 1 year < 5 years
- 5 Years < 10 years
- 10+ years

How often to you visit the dentist for routine visits?

- Less than once a year
- Once a year
- Twice a year
- More than twice a year

Clear selection

For the Likert Scale Below, please indicate an answer by selecting the option which best represents your feelings. *

	Strongly Disagree	Partially Disagree	Neutral	Partially Agree	Strongly Agree
I have a strong relationship with my dentist and their stafff	○	○	○	○	○
I trust my dentist and their staff	○	○	○	○	○
I feel that the dentist tries to sell me treatments	○	○	○	○	○
I have the resources needed to complete treatment plans	○	○	○	○	○
Provider ability in my rural community is a barrier to my treatment	○	○	○	○	○
I view oral health needs as urgent	○	○	○	○	○

For the Likert Scale Below, please indicate an answer by selecting the option which best represents your feelings.

	Strongly Disagree	Partially Disagree	Neutral	Partially Agree	Strongly Agree
I dont view oral health as being connected to my overall health	○	○	○	○	○
The dentist and their staff communicate treatment plans clearly	○	○	○	○	○
The dentist and their staff communicate payments clearly to me	○	○	○	○	○
Fear of pain prevents me from going to the dentist	○	○	○	○	○
I feel educated on oral disease prevention	○	○	○	○	○
Scheduling a timely appointment is difficult	○	○	○	○	○

How could your dentist improve communication, whether that be about treatments, payments, or something else?

Your answer

What could be done to improve your experience at the dentist?

Your answer

Is there anything you wish your dentist understood better about you or your situation?

Your answer

Are there any additional comments you would like to make?

Your answer