John Shoemaker, DDS, DICOI

DENTISTRY

GENERAL, IMPLANT AND COSMETIC

Board-certified International ICOI

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Pt. Name: _____

ID#: _____

Consultation Application

Patient Name: _____ Date: _____

The purpose of your complimentary consultation is to determine **IF** you qualify for Dr. Shoemaker's advanced techniques in dentistry. Dr. Shoemaker can only accept patients that he feels will greatly benefit from his highly sought after advanced training. Not everyone is accepted. Please answer the following completely and thoroughly (use extra paper if needed):

1) **What specifically happened to you that got you to call Dr. Shoemaker?**

_____

_____

2) **What is the ONE THING you hate the most about your dental situation?**

_____

_____

3) **What do you want to hear at your consultation visit with Dr. Shoemaker?**

_____

_____

4) **What 3 factors will impact your decision for moving forward with a solution for your dental problems? List your 3 factors.**

   a. _____

   b. _____

   c. _____

5) **When do you want to start your care?** _____

6) **What is the most important thing you want to see in yourself when your dental care with Dr. Shoemaker is completed?**

_____

7) **What do you feel is your main dental problem? What do you feel is wrong? How long have you suffered?**

_____

_____

8) **Rate how much your dental problem effects you in each area (1 = no effect at all, 10 = it effects me very much):**

Pain: ___ Embarrassment: ___ Eating difficulty: ___ Willingness to Smile:___

9) **Please list everything you've done or tried that hasn't worked: _____**
_____
_____

10) **Why is <u>right now</u> the time get your problems fixed? _____**
_____

11) **How are your dental problems affecting your everyday life?_____**
_____

12) **Do you have (circle) dentures or partials? How long have you had them? Do you wear them every day and all of the time? _____**

<u>Check ALL of the following problems you are experiencing:</u>

- ❑ Avoid eating in public
- ❑ Ashamed to Smile
- ❑ Teeth are unsightly
- ❑ Unattractive Smile
- ❑ Teeth do not look real
- ❑ Loss of Confidence from Teeth
- ❑ Avoid being seen in public
- ❑ Anxiety about your Smile
- ❑ Social Embarrassment
- ❑ Loss of Self Esteem
- ❑ Denture/partial looks phony/fake
- ❑ Withdrawal from social interactions

- ❑ Increased wrinkles
- ❑ Feel older than you are
- ❑ Inconvenience
- ❑ Shrinking bone
- ❑ Difficulty chewing
- ❑ Difficulty swallowing
- ❑ Face falling in
- ❑ Dentures create gagging
- ❑ Loss of support for the face
- ❑ Shrinking gums
- ❑ Change in foods you eat
- ❑ Nutritional/Digestive Disorders

- ❑ Limitations of foods that can be eaten
- ❑ Decreased taste of food
- ❑ Pain on Chewing
- ❑ Teeth are uncomfortable
- ❑ Must use denture adhesive (Upper)
- ❑ Teeth move so much you don't wear them
- ❑ Avoid foods you would like to have
- ❑ Numbness where denture presses
- ❑ Chew better without your partials/dentures
- ❑ Dentures/Partials are painful
- ❑ Must use denture adhesive (Lower)
- ❑ Unstable dentures/partials

- ❑ Sores under dentures/partials
- ❑ Unnatural feel to denture/partial
- ❑ Food trapped between/ under your teeth
- ❑ Difficulty in dealing with stress
- ❑ Difficulty in sleeping
- ❑ Bad breath that won't go away
- ❑ Headaches
- ❑ Dizziness or Ringing in the ears
- ❑ Partials make teeth sore
- ❑ Difficulty speaking
- ❑ Teeth uncomfortable so don't wear them
- ❑ A need to feel whole again
- ❑ Depressed/ insecure about loss of teeth
- ❑ Burning Sensations
- ❑ Teeth/jaw grinding
- ❑ Jaw is sore
- ❑ Previous Traumatic or Bad Dental Experiences
- ❑ Difficulty in dating relationships or sex life because of my teeth
- ❑ Difficulty adjusting to life without my own teeth

Please rank each of the following and how they will influence whether you can get your dental treatment completed:

1 = will not keep me from getting my dental treatment

5 =will very likely keep me from getting my dental treatment

The COST of dental treatment…….	1	2	3	4	5
My FEAR of the dentist……	1	2	3	4	5
My lack of TIME …….	1	2	3	4	5
My EXPECTATIONS are unrealistic	1	2	3	4	5

I have been involved with a legal claim or lawsuit involving a medical/dental provider: Circle (YES)(NO)

Patient Signature_____ Date _____

***** For Doctor Use Only *****

PROBLEMS: _____

_____

_____

Results of Consultation: _____

_____

_____

Notes: _____

_____

☐ **DENIED (WON'T BENEFIT)** ☐ **ACCEPTED (WILL BENEFIT)**