

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?**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **What is the ONE THING you hate the most about your dental situation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **What do you want to hear at your consultation visit with Dr. Shoemaker?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **What 3 factors will impact your decision for moving forward with a solution for your dental problems? List your 3 factors.**
	1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
	2. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
	3. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **When do you want to start your care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **What is the most important thing you want to see in yourself when your dental care with Dr. Shoemaker is completed?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

1. **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: \_\_\_**

1. **Please list everything you’ve done or tried that hasn’t worked: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. **Why is right now the time get your problems fixed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **How are your dental problems affecting your everyday life?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Check ALL of the following problems you are experiencing:**

 Avoid eating in public Avoid being seen in public

 Ashamed to Smile Anxiety about your Smile

 Teeth are unsightly/unattractive Social Embarrassment

 Denture/partial looks phony/fake Loss of Self Esteem/Confidence

 Withdrawal from social interactions Teeth too dark/yellow

 Increased wrinkles Difficulty swallowing

 Feel older than you are  Dentures create gagging

 Change in foods you eat                        Loss of support for the face

 Shrinking bone or gums                            Nutritional/Digestive Disorders

 Difficulty chewing Not enough teeth

 Limitations of foods that can be eaten Avoid foods you would like to have

 Decreased taste of food Numbness where denture presses

 Pain on Chewing  Chew better without your partials/dentures

 Cannot chew well Dentures/Partials are painful

 Must use denture adhesive Teeth are uncomfortable

 Teeth move so much you don’t wear them Unstable dentures/partials

 Sores under dentures/partials Missing several teeth

 Unnatural feel to denture/partial Difficulty speaking

 Food trapped between/ under your teeth Sensitive/hurting teeth

 Loose or broken teeth Headaches
 Jaw is sore Previous Traumatic or Bad Dental Experiences

 Are you interested in a Before and After simulation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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)**