John K. Argeros, D.M.D
Donald E. Plourde, D.M.D
and Associates

Contemporary Dentistry and Implantology

CONSULTATION APPLICATION

Patient Name:_____ Date: _____

The purpose of your complimentary consultation is to determine if you would benefit from the special methods of dentistry that we offer. Not everyone is accepted.

Please answer the following completely and thoroughly (use extra paper if needed):

1. What do you want to hear at your consultation with Dr. Argeros?
   _____
   _____
   _____

2. What is the most important thing you want to see in yourself when your dental care with us is completed?
   _____
   _____
   _____

3. What specifically happened to you that got you to call us?
   _____
   _____
   _____

4. What do you feel is your main dental problem? What do you feel is wrong? When did it start and how long have you suffered?
   _____
   _____
   _____

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5. Rate how much your dental problem impacts you in each area (1=No Affect at all, 10=It Affects me very much):

   Pain: _____ Embarrassment: _____ Eating Difficulty: _____ Ability to Smile: _____

6. Please list everything that you have done or tried that hasn't worked:

   _____
   _____
   _____

7. Why do you feel that right now is the time to get your problems fixed?

   _____
   _____
   _____

8. How are your dental problems affecting your everyday life?

   _____
   _____
   _____

9. If you have (circle) dentures or partials. How long have you had them? Do you wear them every day and all of the time?

   _____
   _____
   _____

10. Please tell us about any dental experiences that were upsetting to you.

    _____
    _____
    _____

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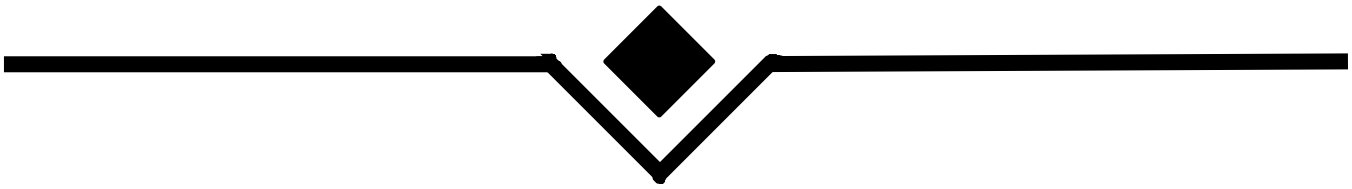

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Do you feel you suffer from these effects of missing teeth and failing teeth? (Check all that apply to you).

___ Avoid eating in public
___ Pain on chewing
___ Difficulty in dealing with stress
___ Difficulty in sleeping
___ Change in foods you eat
___ Face falling in
___ Inconvenience
___ Shrinking bone
___ Must use denture adhesive
___ Gag reflex
___ A need to feel whole again
___ Feel older than you are
___ Loss of self esteem
___ Unattractive smile
___ Unstable dentures
___ Mouth sores
___ Unnatural feel
___ Ashamed to smile
___ Shrinking gums
___ Numbness in face and lips
___ Withdrawal from social interaction
___ Dizziness or ringing in the ears
___ Teeth are unsightly
___ Avoid certain foods
___ Teeth are uncomfortable
___ Depressed or insecure about loss of teeth
___ I chew better without my partials or dentures
___ Bad breath constantly
___ Avoid being seen in public
___ Anxiety about your smile
___ Social embarrassment
___ Difficulty swallowing
___ Altered taste of food
___ Nutritional disorders
___ Loss of support for the face
___ Ill-fitting partials
___ Unattractive partials
___ Teeth don't look real
___ Difficulty chewing
___ Difficulty speaking
___ Burning sensations
___ Limitation on foods that I can eat
___ Increased wrinkles
___ Digestive disorders
___ Headaches
___ Food trapped between / under your teeth
___ Teeth grinding
___ Teeth move so much I don't wear them
___ Avoid foods I would like to have
___ Jaw is sore
___ Previous bad dental experiences
___ Difficulty in adjusting to life without your own teeth
___ Difficulty in dating or sex life because of your teeth

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

1 = won't prevent me from getting my dental treatment

5 = will likely prevent me from getting my dental treatment

The cost of 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

I have unrealistic expectations …….. 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 Doctors Use Only

Problems:

_____

_____

_____

Results of Consultation:

_____

_____

_____

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