Sunset Valley Dental
Dr. Janisse Implant and Restorative Dentistry
Northwest Implant Research Group
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Dental Implant Study Application

Patient Name: _____ Date: _____

The purpose of your complimentary research study consultation is to determine **IF** you are a candidate for this study involving dental implants for denture wearers. Dr. McAnally can only accept patients that he feels will greatly benefit from being in the study and from his highly sought after Dr. Janisse's Method Dentistry. Not everyone is accepted. Treatment under the study is not free BUT your cost is slightly reduced.

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

1) **How long have you been wearing dentures?_____**
2) **What is the #1 thing you hate the most about your dentures?**
   _____
   _____
3) **What specifically happened to you that got you to call Dr. McAnally?**
   _____
   _____
4) **When do you want to start treatment?_____**
5) **Why do you feel you are a good candidate for this study?**
   _____
   _____
   _____
   _____

6) **Rate how much your dental problem effects you in each area (1 = no effect at all, 10 it effects you very much):**
Pain: ___ Embarrassment: ___ Eating difficulty: ___ Willingness to Smile:___

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

_____

_____

8) **Why do you feel <u>right now</u> is the time to get y our dental problems fixed?**

_____

_____

9) **Do you smoke?_____ If yes, how many packs per day?_____ How many years have you smoked?_____**

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

_____

11) **Do you wear your dentures all of the time? _____**
_____

_____

_____

12) **Please tell us about any dental experiences that were upsetting to you?**

_____

_____

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
- ☐ Social Embarrassment
- ☐ Unattractive Smile
- ☐ Loss of Self Esteem
- ☐ Teeth do not look real
- ☐ Denture/partial looks phony/fake
- ☐ Loss of Confidence from Teeth
- ☐ Withdrawal from social interactions

- ☐ Increased wrinkles
- ☐ Face falling in
- ☐ Feel older than you are
- ☐ Dentures create gagging
- ☐ Inconvenience
- ☐ Loss of support for the face
- ☐ Shrinking bone
- ☐ Shrinking gums

- ☐ Difficulty chewing
- ☐ Change in foods you eat
- ☐ Difficulty swallowing
- ☐ Nutritional/Digestive Disorders
- ☐ 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

- ☐ Teeth are uncomfortable
- ☐ Dentures/Partials are painful
- ☐ Must use denture adhesive (Upper)
- ☐ Must use denture adhesive (Lower)
- ☐ Teeth move so much you don't wear them
- ☐ Unstable dentures/partials
- ☐ Sores under dentures/partials
- ☐ Partials make teeth sore
- ☐ Unnatural feel to denture/partial
- ☐ Difficulty speaking
- ☐ Food trapped between/ under your teeth
- ☐ Teeth uncomfortable so don't wear them

- ☐ Difficulty in dealing with stress
- ☐ A need to feel whole again
- ☐ Difficulty in sleeping
- ☐ Depressed/ insecure about loss of tee

TURN THE PAGE

- ☐ Bad breath that won't go away
- ☐ Headaches
- ☐ Dizziness or Ringing in the ears
- ☐ 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 problems and how they will influence whether you 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 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)

By signing below, I agree to participate in the study if found eligible and to allow my treatment to be documented and to be included in any published study results. I also agree that photos and descriptions (photos, audio, and video) that I give as part of my treatment experience can be used to show other patients the benefits of implant dentistry and this study.

Patient Signature _____ Date _____

***** For Research Study Use Only *****

PROBLEMS: _____
_____
_____
_____

Results of Consultation: _____
_____
_____

Notes: _____
_____

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