Sunset Valley Dental Dr. Janisse Implant and Restorative Dentistry Northwest Implant Research Group 144 Palmer Court Wilder, VT 05088 www.Sunetvalleydental.com

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?

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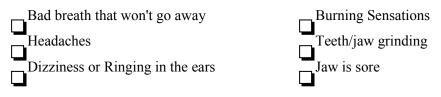
Rate how much your dental problem effects you in each area (1 = no effect at all, 10 it effects you very much): Pain: Embarrassment: Eating difficulty: Willingness to Smile:
Please list everything you've done or tried that hasn't worked:
Why do you feel <u>right now</u> is the time to get y our dental problems fixed?
Do you smoke? If yes, how many packs per day? How many years have you smoked?
How are your dental problems affecting your everyday life?
Do you wear your dentures all of the time?
Please tell us about any dental experiences that were upsetting to you?

NWIRG

Check ALL of the following problems you are experiencing:

	NWIRG	TURN THE PAG
Difficulty in dealing with stress	A need to feel who Depressed/ insecur	-
Difficulty in dealing with stress	A need to feel who	la again
Food trapped between/ under your teeth	Teeth uncomfortab	le so don't wear them
Unnatural feel to denture/partial	Difficulty speaking	5
Sores under dentures/partials	Partials make teeth	sore
Teeth move so much you don't wear the	m Unstable dentures/pa	artials
Must use denture adhesive (Upper)	Must use denture a	dhesive (Lower)
Teeth are uncomfortable	Dentures/Partials a	re painful
Pain on Chewing		it your partials/dentures
	Numbness where d	_
Limitations of foods that can be eaten Decreased taste of food	-	
Difficulty swallowing		
Difficulty chewing	Change in foods yo	ou eat
Shrinking bone	Shrinking gums	
	\Box Loss of support for	the face
Feel older than you are	Dentures create gag	
Increased wrinkles	Face falling in \Box_{-}	
Loss of Confidence from Teeth	Withdrawal from se	ocial interactions
Teeth do not look real	Denture/partial loo	ks phony/fake
Unattractive Smile	Loss of Self Esteen	n
Teeth are unsightly	Social Embarrassm	ent
Ashamed to Smile	Anxiety about your	Smile
Avoid eating in public	Avoid being seen in	n public

<mark>GE</mark>



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
	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 ***

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DENIED (WON'T BENEFIT)	
Notes:	
Results of Consultation:	
PROBLEMS:	