Sunset Valley Dental
Implant and Restorative Dentistry
144 Palmer Court
Wilder, VT 05088
802-649-8277 Fax: (802) 649-8484

Consultation Application

Patient Name: ______________________________ **Date:** _____________

The purpose of your complimentary consultation is to determine **IF** you qualify for Dr. Janisse's Special Methods of Dentistry. Dr. Janisse can only accept patients that he feels will greatly benefit from his highly sought after Dr. Janisse Method™. 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. Janisse?**
   ____
   ____

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. Janisse?**
   ____
   ____

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. ______________________________

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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. Janisse 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> is 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? ___________________

____

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

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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

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❑ Difficulty in dealing with stress
❑ Difficulty in sleeping
❑ A need to feel whole again
❑ Depressed/ insecure about loss of teeth

❑ 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 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: ____
____
____

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Notes: ____
____

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

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