CONSULTATION SURVEY APPLICATION

DATE_____

PATIENT NAME_____

PATIENT ADDRESS_____

BIRTHDATE_____ SEX ____(male) _____(female)

PHONE NUMBERS_____(home) _____(work)

_____(cell) E-MAIL_____

Please answer the following completely and thoroughly.

1) What do you want to hear at your consultation visit with Smiles for Life?_____
2) What is the most important thing you want to see in yourself when dental care with Smiles for Life is completed?

   _____
3) What specifically happened to you that got you to call Smiles for Life?_____
4) What do you feel is your main dental problem? When did it start and how long have you suffered?

   _____

   _____
5) Rate how much your dental problem affects you in each area (1 = no affect 10 it affects me very much):

   _____ Embarrassment _____ Eating Difficulty _____Ability to Smile
6) Why do you feel right now is the time to get your problems fixed?

   _____
7) How are your dental problems affecting your everyday life?_____
8) Do you have (circle) dentures or partials? How long have you had them? Do you wear them every day and all of the time? _____
9) Please tell us about any dental experiences that were upsetting to you._____

   _____
10) Please list everything you've done or tried that hasn't worked._____

PLEASE CHECK ALL THAT APPLY TO YOU IF YOU SUFFER FROM THESE EFFECTS OF MISSING AND FAILING TEETH

____ Eating in public

____ Difficulty chewing

____ Difficulty in dealing with stress

____ Difficulty in sleeping

____ Change in foods you eat

____ Face falling in

____ Inconvenience

____ Shrinking bone

____ Ill-fitting or unattractive partial

____ A need to feel whole again

____ Feel older than you are

____ Teeth that don't look real

____ Mouth sores

____ Unstable dentures

____ Unnatural feel

____ Limitations of foods that you can eat

____ Shrinking gums

____ Numbness in face and lips

____ Withdrawal from social interaction

____ Food trapped between/under teeth

____ Dizziness or ringing in the ears

____ Difficulty adjusting to life without your own teeth

____ Depressed/insecure about loss of teeth

____ Difficulty in dating relationships or sex life because of teeth

____ You chew better without your partial/dentures

____ 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

____ Must use denture adhesive

____Gag reflex

____ Bad breath that won't go away

____ Loss of self esteem

____ Unattractive smile

____ Difficulty speaking

____ Burning sensations

____ Ashamed to smile

____ Increased wrinkles

____ Digestive disorders

____ Headaches

____ Teeth grinding

____ Avoid foods you would like to eat

____ Jaw is sore

____ Teeth are uncomfortable

____ Previous bad dental experience