Patient Application Form

imagecare DENTAL

Patient Name:

The purpose of your first consultation is to determine **if** you are good fit with Imagecare Method of Solving Dental Problems. Due to time constraints, Dr. Thompson can only accept patients who can greatly benefit from the options he customizes for each patient. If you aren't an acceptable fit, a referral will be offered to another doctor.

Please answer the following completely and thoroughly:

1) What specifically motivated you to make your first appointment?

2) What is the ONE THING you dislike the most about your dental situation?

3) What do you want to hear at your consultation visit with Dr. Thompson?

4) When is the best time to start your care?

5) What is the most important thing you want to see in yourself when your dental care with Dr. Thompson would be completed?

6) What do you feel is your most pressing dental problem? What do you feel is wrong? How long have you suffered?

7) Rate how much of a problem you are having with the following:
(1 = no problem 10 = major problem affecting my life)

- ☐ Pain
- ☐ Embarrassment
- ☐ Eating difficulty
- ☐ Willingness to Smile

8) Please list what you've done or tried that hasn't worked:

9) Why do you feel that right now is the time get your problems fixed?

10) Describe how your dental problems affect your everyday life?

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

12) Please tell us about any recent dental experiences that were upsetting.

Check ALL of the following that apply to you:

- ☐ *I avoid eating in public*
- ☐ *I'm ashamed to smile*
- ☐ *My teeth are unsightly*
- ☐ *My smile is unattractive*
- ☐ *My teeth do not look natural*
- ☐ *I've lost confidence due to my teeth*
- ☐ *I avoid being seen in public*
- ☐ *I'm anxious about my smile*
- ☐ *My teeth cause social embarrassment*
- ☐ *I've lost self-esteem due to my teeth*
- ☐ *My denture/partial looks phony or fake*
- ☐ *I avoid social interactions*

- ☐ *I've noticed more facial wrinkles*
- ☐ *I feel older than my natural age*
- ☐ *My teeth are creating inconvenience*
- ☐ *I have shrinking bone structure*
- ☐ *I've lost facial support due to my teeth*
- ☐ *My dentures create gagging*
- ☐ *My facial features are collapsing*
- ☐ *I've noticed my gums shrinking*

- ☐ *I have difficulty chewing*
- ☐ *I risk choking from swallowing*
- ☐ *I am limited in food choices*
- ☐ *I don't taste things the same as I did*
- ☐ *It hurts to chew*
- ☐ *I've altered the types of foods I eat*
- ☐ *Nutritional/Digestive Disorders*
- ☐ *There are foods I'd like to eat again*
- ☐ *I have numbness where my denture presses*
- ☐ *I eat better without my partials/dentures*

- ☐ *My teeth are uncomfortable*
- ☐ *I use denture adhesive (Upper)*
- ☐ *My teeth move so much I don't wear them*
- ☐ *I get sores under my dentures/partials*
- ☐ *My denture/partial feels unnatural*
- ☐ *I get food trapped between/under my teeth*
- ☐ *My dentures/Partials are painful*
- ☐ *I must use denture adhesive (Lower)*
- ☐ *My dentures/partials rock*
- ☐ *My partials make my teeth sore*
- ☐ *My denture/partial makes speech difficult*
- ☐ *My teeth are too uncomfortable to wear*

- ☐ *I have difficulty in dealing with stress*
- ☐ *I have difficulty in sleeping*
- ☐ *I have bad breath that won't go away*
- ☐ *I have frequent headaches*
- ☐ *I have dizziness/ringing in my ears*
- ☐ *I snore when sleeping*
- ☐ *I'd like to feel whole again*
- ☐ *I feel depressed/insecure about my teeth*
- ☐ *I have burning sensations in my mouth*
- ☐ *I grind or clench my teeth*
- ☐ *My jaw is sore at times*

- ☐ *I've had previous traumatic dental experiences*
- ☐ *I find difficulty in dating, relationships, or my sex life because of my teeth*
- ☐ *It's been difficult to adjusting to life without my own teeth*

Please rank each of the following on how each would affect your dental treatment.

1 = will NOT prevent me from getting my dental treatment finished

5 = will likely prevent me from getting my dental treatment finished

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: ☐ YES ☐ NO

Patient Signature: _____

***** FOR DOCTOR THOMPSON AT CONSULTATION *****

PROBLEMS: _____

_____

_____

Results of Consultation: _____

_____

_____

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

SUBMIT