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Cosmetic and Implant Questionnaire

Patient Name: _____ Date:_____

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

1) What do you want to hear at your consultation visit with Dr. Hughes?

_____

_____

2) What is the most important thing you want to see in yourself when your dental care with Dr. Hughes is completed?

_____

_____

3) What specifically happened to you that got you to call Dr. Hughes?

_____

_____

4) What do you feel is your main dental problem? What do you feel is wrong? When did it start and how long have you suffered?

_____

_____

5) 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: ____ Ability to Smile: ____

6) Please list everything you have done or tried that has not worked:

_____

_____

7) Why do you believe right now is the time to get your problems fixed?

_____

_____

8) How are your dental problems affecting your everyday life?

_____

_____

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

_____

_____

10) Please tell us about any dental experiences that are upsetting to you?

_____

_____

DO YOU FEEL/BELIEVE YOU SUFFER FROM THESE EFFECTS OF MISSING AND FAILING TEETH? (Check all that apply to you.)

____Avoid eating in public.

____Avoid being seen in public.

____Pain upon chewing.

____Anxiety about your Smile.

____Difficulty in dealing with stress.

____Social Embarrassment

____Difficulty in Sleeping.

____Difficulty swallowing

____Change in foods you eat.

____Altered taste of food.

____Face falling in

____Inconvenience

____Shrinking bone

____Must use denture adhesive (Lower)

____Gag Reflex

____Bad breath that will not go away.

____Loss of Self Esteem

____Unattractive smile

____Mouth Sores

____Unstable dentures

____Unnatural Feel

____Ashamed to smile

____Shrinking gums

____Numbness in face and lips.

____Withdrawal from social interaction.

____Dizziness or Ringing in the ears.

____Teeth are unsightly.

____Avoid certain foods.

____Teeth are uncomfortable.

____Nutritional Disorders

____Loss of support for the face.

____Must use denture adhesive (Upper)

____Ill fitting or unattractive partials.

____A need to feel whole again.

____Feel older than you are.

____Teeth do not look real.

____Difficulty Chewing

____Difficulty Speaking

____Burning sensations

____Limitations of foods that can be eaten.

____Increased Wrinkles

____Digestive Disorders

____Headaches

____Food trapped between/under your teeth.

____Teeth grinding

____Teeth move so much, I do not wear them.

____Avoid foods I would like to enjoy.

____Jaw is sore.

____Depressed/insecure about loss of teeth.

____Previous Bad Dental Experiences

____I chew better without my dentures/partials.

____Difficulty in dating relationships or sex life because of your teeth.

____Difficulty adjusting to life without your own teeth.

Please rank each of the following problems and how they will influence whether you get your dental treatment completed:

1 = Will not prevent me from getting my dental treatment.
5 = Will likely prevent 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
I have UNREALISTIC EXPECTATIONS.....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 HUGHES' USE ONLY*****

PROBLEMS:_____

_____

_____

Results of Consultation:_____

_____

_____

Notes:_____

_____

_____DENIED (WILL NOT BENEFIT) ____ACCEPTED (WILL BENEFIT)