G. GARY GREEN, DMD
General and Cosmetic Dentistry
277 Bloomfield Avenue, Caldwell, NJ 07006
(973) 228-0252 **Fax:** (973) 228-0918
www.caldwellnjdentist.com
Email: garygreendmd@gmail.com

Patient Name: _____ Date:_____

The purpose of your complimentary consultation is to determine IF you qualify for Dr. Green's Special Methods of Dentistry. Dr. Green can only accept patients that he feels will greatly benefit from his highly sought after Dr. Green 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. Green?
_____
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. Green?
_____
4.) What 3 factors will impact your decision for moving forward with a solution for your dental problems? List your 3 factors.

1.) _____
2.) _____
3.) _____

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. Green 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 right now 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?

_____

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 / Loss of confidence
- ☐ 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 / changes in food habits
- ☐ 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
- [ ] Difficulty in dealing with stress
- [ ] A need to feel whole again
- [ ] Difficulty in sleeping
- [ ] Depressed/insecure about loss of teeth
- [ ] Bad breath that won't go away
- [ ] Burning sensations
- [ ] Headaches
- [ ] Teeth / jaw grinding
- [ ] Dizziness or ringing in the ears
- [ ] Jaw is sore
- [ ] Previous traumatic or bad dental experiences
- [ ] 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:_____
PROBLEMS: _____
Results of Consultation: _____
Notes:_____