

Consultation Application

Patient Name: _____ **Date:** _____

The purpose of your complimentary consultation is to determine **IF** you qualify for Dr. Sutherland's Digital Dentistry. Dr. Sutherland can only accept patients who he feels will greatly benefit from his highly sought-after dentistry. **Not everyone is accepted.**

Please answer the following questions completely and thoroughly.

1) **What specifically happened to you that got you to call Dr. Sutherland?**

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. Sutherland?**

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. _____

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. Sutherland 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 affects you in each area.
(1 = no effect at all. 10 = affects 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?

Please rank the items below as how they will influence whether you get your dental treatment completed:

1 = will **not** keep me from getting my dental treatment

5 = will 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

Patient Signature _____

Date _____

***** For Dr. Sutherland's Use Only *****

Problems: _____

Results of Consultation: _____

Notes: _____

DENIED (WON'T BENEFIT)

ACCEPTED (WILL BENEFIT)