David T. Rothan, DDS, General Dentist • Michael J. Rothan, DDS, General Dentist

Consultation Application

Patient Name: ______________________________________**Date:** ___________________

The purpose of your complimentary consultation is to determine **IF** you qualify for Dr. Rothan's Special Method Dentistry. Dr. Rothan can only accept patients that he feels will greatly benefit from his highly sought after 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. Rothan?**
____
____
____

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. Rothan?**
____
____
____

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. Rothan is completed?**
____
____
____
____

What do you feel is your main dental problem? What do you feel is wrong? How long have you suffered?

____

____

____

7) **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:___

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

____

____

9) **Why is <u>right now</u> -- the time to get your problems fixed?**

____

____

10) **How are your dental problems affecting 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 dental experiences that were upsetting to you?**____

____

____

____

____

____

____

____

____

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 ______________

***** For Doctor Use Only *****

PROBLEMS: ____

____

____

Results of Consultation: ____

____

____

Notes: ____

____

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