

By taking the time to answer these questions honestly, we will have a clearer understanding of you and your dental condition. It is our goal to offer you a comprehensive consultation and provide the optimum treatment for you. The answers to these questions will assist us in this endeavor. Thank you for your time.

Denture or partial wearers **PATIENT NAME:** _____

How long have you had your denture/partial? _____

How many sets of dentures/partials have you had? _____

Do you need the use of adhesives to hold your denture/partial in place? _____

Are you aware of your denture/partial moving while you speak, smile or laugh? _____

Does your denture/partial come loose when eating? _____

Does your denture/partial cause you pain when you eat? _____

Does food get caught under your denture/partial when you eat? _____

Have you ever avoided eating in public because you were afraid that you denture/partial had come loose? If yes, please describe. _____

Has an embarrassing situation ever happened because your denture/partial had come loose? If yes, please describe. _____

Are you able to eat all the foods you used to eat before you had your denture/partial? If no, what are you now unable to eat? _____

Are there any activities that you have had to give up because you wear dentures/partials? If yes, please explain. _____

Are you satisfied with your denture/partial? If no, what would you like to change? _____
