

PATIENT NAME: _____

Anyone missing one or more teeth (Please circle "Y" for yes or "N" for no)

- Y N Have you noticed any shifting of your remaining teeth since the loss of your tooth/teeth?
- Y N Has the loss of a tooth and/or teeth affected your ability to chew or eat any foods?
- Y N Has the loss of a tooth and/or teeth made maintaining your mouth more difficult?
- Y N Have you noticed consistent bad breath since the loss of your tooth/teeth?
- Y N Have you become more self-conscious about your smile since the loss of your tooth/teeth?
- Y N Are you embarrassed by your smile due to the loss of a tooth/teeth?
- Y N Do you attend fewer social gatherings because you feel that you have an unattractive smile?
- Y N Has anyone ever commented on your missing teeth?
- Y N If replacing your missing tooth/teeth was an option, would you pursue it?
If yes, what would be an obstacle to pursuing this care? List as many that apply.
