

Your Name:
Date:
How did you hear of us?
Do you wear ___an upper denture, ___a lower denture, or ___both?
Approximately when was your first (set of) denture(s) made?
How many (sets of) dentures have you had made?
When was your present (set of) denture(s) made?
Please check if you have had any of the following problems with your present dentures: <ul style="list-style-type: none"> <input type="checkbox"/> Discomfort <input type="checkbox"/> Looseness <input type="checkbox"/> Slipping <input type="checkbox"/> Inability to eat certain foods <input type="checkbox"/> Unhappy with your appearance <input type="checkbox"/> Wearing "mismatched" dentures <input type="checkbox"/> Prefer to wear no dentures
When your present dentures were new, did you have any of these problems?
If yes, which problems?

In making new dentures, please tell us what is important to you:

	Very important	Important	Average	Not Important
Appearance				
Comfort				
Fit				
Function				

Our mission is to deliver excellence in dentistry to all of our patients, and to give each patient the individual attention they deserve. Please tell us anything else about your dentures or your dental experience that you feel we should know that could better help you.