Assessment of Dentures *(if required)* — Form 10

For office use

CHI Number D D M M Y Y [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Surname ______________________

Forename ______________________

Age [ ][ ]   Sex [ ]

Examination Date

Day [ ][ ] Month [ ][ ] Year [ ][ ][ ][ ]

Patient's Assessment of Dentures

	Yes	No	Unsure
Are you happy with the appearance of your dentures?	[ ]	[ ]	[ ]
Do your dentures move?	[ ]	[ ]	[ ]
Are your dentures comfortable?	[ ]	[ ]	[ ]
Do your dentures affect your speech?	[ ]	[ ]	[ ]
Are you able to chew adequately?	[ ]	[ ]	[ ]
Are you able to bite adequately?	[ ]	[ ]	[ ]

Clinician's Assessment of Dentures

Denture Base Material

Acrylic [ ]   Cobalt Chrome [ ]

Denture Hygiene

Good [ ]

Fair [ ]

Poor [ ]

Type of Denture

F/F [ ]	P/P [ ]	F/P [ ]
P/F [ ]	F/– [ ]	–/F [ ]
P/– [ ]	–/P [ ]	

Upper Denture

Upper Denture	Good	Poor	N/A		Good	Poor	N/A
Tissue adaption	[ ]	[ ]	[ ]	Incisal level	[ ]	[ ]	[ ]
Base extension	[ ]	[ ]	[ ]	Incisal plane	[ ]	[ ]	[ ]
Labial	[ ]	[ ]	[ ]	Position of posterior teeth	[ ]	[ ]	[ ]
Buccal	[ ]	[ ]	[ ]	Occlusal plane level	[ ]	[ ]	[ ]
Posterior border	[ ]	[ ]	[ ]	Occlusal plane orientation	[ ]	[ ]	[ ]
Tuberosity	[ ]	[ ]	[ ]	Arch width	[ ]	[ ]	[ ]
Labial fullness	[ ]	[ ]	[ ]	Buccal–lingual width	[ ]	[ ]	[ ]

Alteration proposed / Notes

PTO

Assessment of Dentures *(if required)* **Form 10** (cont.)

Lower Denture	Good	Poor	N/A		Good	Poor	N/A
Tissue adaption	☐	☐	☐	Labial fullness	☐	☐	☐
Base extension	☐	☐	☐	Position of posterior teeth	☐	☐	☐
Labial	☐	☐	☐	Occlusal plane level	☐	☐	☐
Buccal	☐	☐	☐	Arch width	☐	☐	☐
Posterior border	☐	☐	☐	Buccal–lingual width	☐	☐	☐
Lingual	☐	☐	☐	Cusp form	☐	☐	☐
Distolingual	☐	☐	☐				

Alteration proposed / Notes

Relationship of Dentures

Occlusal Position *(Select one)*

Retruded	☐
Protruded	☐
Intercuspal / Muscular	☐

Occlusal Contacts	Good	Poor	N/A
Articulation	☐	☐	☐
Occlusal vertical dimension	☐	☐	☐
Incisal overjet	☐	☐	☐
Incisal overbite	☐	☐	☐

Alteration proposed / Notes

Aesthetics

	Good	Poor
Mould / Arrangement	☐	☐
Shade	☐	☐

Alteration proposed / Notes

Signature of Practitioner ______________________ **Date** ______________