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	Good	Poor	N/A
Tissue adaption	☐	☐	☐
Base extension	☐	☐	☐
Labial	☐	☐	☐
Buccal	☐	☐	☐
Posterior border	☐	☐	☐
Tuberosity	☐	☐	☐
Labial fullness	☐	☐	☐

	Good	Poor	N/A
Incisal level	☐	☐	☐
Incisal plane	☐	☐	☐
Position of posterior teeth	☐	☐	☐
Occlusal plane level	☐	☐	☐
Occlusal plane orientation	☐	☐	☐
Arch width	☐	☐	☐
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	Alteration proposed / Notes
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	☐	☐	☐					

Relationship of Dentures

Occlusal Position *(Select one)*

- Retruded ☐
- Protruded ☐
- Intercuspal / Muscular ☐

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

Aesthetics

	Good	Poor	Alteration proposed / Notes
Mould / Arrangement	☐	☐	
Shade	☐	☐	

Signature of Practitioner _____ **Date** _____