Dentistry at its finest

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# *Dentistry At Its Finest*

***Patient Name :*** _____

## FULL DENTURES QUESTIONNAIRE

1. Are you missing out in life because you have no teeth and wear dentures? ☐ Yes ☐ No
2. Do you look and feel much older than or really are? ☐ Yes ☐ No
3. Are your dentures loose? ☐ Yes ☐ No
4. Do you need denture paste multiple times a day to get by? ☐ Yes ☐ No
5. Does it hurt to chew the foods you used to love to eat? ☐ Yes ☐ No
6. What are your favorite foods that you have problems eating?

   _____
7. When I smile, I look like I have no teeth? ☐ Yes ☐ No
8. When I smile, my teeth look fake or like a picket fence? ☐ Yes ☐ No
9. Are you camera shy because of the way your face and teeth look? ☐ Yes ☐ No
10. Do you already have a set of dentures or are you considering your first set? ☐ Yes ☐ No
11. At what age was your first denture? _____
12. How many sets of dentures have you had made? _____
13. Do you want a solution to your problems without dental implant treatment? ☐ Yes ☐ No ☐ Not Sure
14. Do you want a solution to your problems using dental implants if you are a candidate? ☐ Yes ☐ No
15. Do you want non-removable teeth or would you be happy with removable teeth if they make your look and feel great? ☐ Removable ☐ Non-removable ☐ Either
16. What size problem in your life are your dentures?
    - ☐ Ruining my life
    - ☐ Very Unhappy
    - ☐ Think about it everyday I've learned to "get by"
    - ☐ Moderate Problem
    - ☐ Slight Problem
    - ☐ None
17. Have you discussed this problem with any other dentists recently? ☐ Yes ☐ No

    *What did they tell you or suggest to you?*

    _____
18. If you could wave a magic wand and create any result, what would you like to see happen?

    _____

    _____

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19. Is there anything you like Dr. Matarazzo to know about yourself, your problems or what you are thinking?

    _____

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Signature of Patient: _____ Date: MM / DD / YYYY