

Patrick C. Haggerty, D.D.S., Inc.
Patient Questionnaire

Name _____ Date _____
Address _____
Home Telephone _____ Work Telephone _____
Date of Birth _____ Occupation _____

1. Are you missing any teeth in your upper jaw? Yes No Lower jaw? Yes No
If you have any remaining teeth, how do you feel about the condition of your teeth? _____

2. How do you feel about your smile? _____

3. When were your teeth removed? _____

4. For what reason(s) were your teeth removed? _____

5. Has your loss of teeth led to or affected any of the following?
 Changes in appearance Decrease in self-confidence Physical discomfort
 Your professional life Your personal life Health problems
 Diet changes Discomfort in social situations (smiling, etc.)

6. Are you concerned about any of the following?
 Health of the remaining teeth Facial appearance and premature aging
 Shrinkage of the jawbone due to missing teeth Physical discomfort
 Appearance of your smile Other _____

7. If you have a partial / denture, what type do you have? Full Partial

8. Do you wear your partial / denture all day? Yes No

9. If there are times that you do not wear your partial / denture, please describe the reason(s): _____

10. Do you ever experience difficulty wearing the partial / denture for any of the following reasons?
 Its appearance Difficulty eating Difficulty speaking
 It does not fit well It is uncomfortable It is painful

11. How often have adjustments been made to the partial / denture and when was it last adjusted? _____

12. Have you ever had your partial / denture replaced? Yes No

13. Do you feel that your partial / denture fits better when you first began wearing it, than it does now?
Upper Jaw Yes No Lower Jaw Yes No

14. Which gives you the most trouble? Upper Lower

15. What is the main concern or problem that you would like to resolve with replacement teeth? _____

16. What benefits do you expect from replacement teeth? _____