DENTURE ASSESSMENT

LONG TERM CARE
ORAL HEALTH PROGRAM
HOME: ______________________________

Resident's full name: ____

Type of Denture	Maxilla	Mandible	Comments
	❑ No denture ❑ Complete upper ❑ Partial Upper	❑ No denture ❑ Complete upper ❑ Partial Upper	
Resident's perception	❑ Not applicable ❑ Acceptable ❑ Unacceptable	❑ Not applicable ❑ Acceptable ❑ Unacceptable	
Dentist's perception	❑ Not applicable ❑ Acceptable ❑ Unacceptable	❑ Not applicable ❑ Acceptable ❑ Unacceptable	
Retention	❑ Not applicable ❑ Acceptable ❑ Unacceptable	❑ Not applicable ❑ Acceptable ❑ Unacceptable	
Peripheral seal	❑ Not applicable ❑ Acceptable ❑ Unacceptable	❑ Not applicable ❑ Acceptable ❑ Unacceptable	
Border extension buccal **Lingual** **Posterior**	❑ Not applicable ❑ Acceptable ❑ Unacceptable ❑ Not applicable ❑ Acceptable ❑ Unacceptable ❑ Not applicable ❑ Acceptable ❑ Unacceptable	❑ Not applicable ❑ Acceptable ❑ Unacceptable ❑ Not applicable ❑ Acceptable ❑ Unacceptable ❑ Not applicable ❑ Acceptable ❑ Unacceptable	
Vertical Dimension	❑ Not applicable ❑ Acceptable ❑ Unacceptable	❑ Not applicable ❑ Acceptable ❑ Unacceptable	