



## Denture Acceptance Form

**Patient's Full Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Date of Appointment:** \_\_\_\_\_

**Dentist/Provider Name:** \_\_\_\_\_

### Denture Treatment Overview:

Description of the dentures provided (e.g., full dentures, partial dentures):

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### Patient Acknowledgments:

By signing this form, I confirm that I have been informed of the following regarding my denture treatment:

**1. Denture Fitting and Function**

I understand that my dentures have been carefully designed to fit my mouth and meet my functional and aesthetic needs. I have tried the dentures for fit and comfort, and they have been adjusted as necessary during my visits.

**2. Care Instructions**

I have received clear instructions on how to properly care for and clean my dentures, including any necessary adjustments and follow-up visits.

**3. Adaptation Period**

I understand that it may take time to adapt to wearing dentures, and some discomfort may be experienced during the adjustment phase. I am aware that the dentist will guide me through this process and make any necessary adjustments.

**4. Possible Side Effects**

I have been informed of potential side effects that may include sore spots, difficulty speaking or chewing, or discomfort. I understand that any persistent issues should be reported to the office for further evaluation and adjustment.

**5. Follow-Up Care**

I understand that follow-up visits may be required to ensure the proper fit of my dentures, and I will schedule these appointments as advised by my dentist.

**6. Long-Term Care**

I acknowledge that my dentures may require replacement or relining in the future due to changes in my oral condition or the natural wear of the dentures.

**Patient's Declaration:**

I hereby accept the dentures provided to me and understand the following:

- The dentures have been designed to meet my needs, and I am satisfied with the fit, function, and appearance at this time.
- I understand the care instructions and will follow them to ensure the longevity of my dentures.
- I acknowledge that the dental office is available to assist me with any issues or adjustments after receiving my dentures.

**Patient's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Dentist's Signature (or Staff Member):** \_\_\_\_\_

**Date:** \_\_\_\_\_

***Additional Notes***

- A follow-up appointment is scheduled for: \_\_\_\_\_
- The patient is encouraged to contact the office with any questions or concerns regarding their dentures.