BALANCED DENTAL

NAME: _____ DATE: _____

PRIMARY REASON FOR APPT: ☐ Exam ☐ Emergency ☐ Consultation

We understand nobody likes paperwork, however, accurately answering the following questions will allow us to provide you with the individualized care you need. Your answers will remain confidential and will only be used for your assessment. We appreciate your time and consideration.

DENTAL HISTORY

	Yes	No
1. Are you currently experiencing discomfort? Describe: _____	☐	☐
2. Have you seen a dental care provider on a routine basis? Last visit: _____ Cleaning: _____	☐	☐
3. Approximate date of full mouth xrays (16 films or panoramic): _____		
4. Name of last dentist (optional): _____		
5. Reason for leaving (optional): _____		
6. Have you ever been treated for periodontal/gum disease? Procedure type: _____	☐	☐
7. How often do you brush? _____		
8. Does dental treatment make you nervous? Explain: _____	☐	☐

Have you experienced any of the following:

Yes	No		Yes	NO	
☐	☐	Bleeding or sore gums	☐	☐	Loose teeth
☐	☐	Unpleasant taste/bad breath	☐	☐	Sensitive to hot
☐	☐	Burning tongue/lips	☐	☐	Sensitive to cold
☐	☐	Fever blister on lip or mouth	☐	☐	Sensitive to sweets
☐	☐	Swelling/lumps in the mouth	☐	☐	Discomfort when biting
☐	☐	Ortho treatment/braces	☐	☐	Food often getting stuck/impacted
☐	☐	Biting cheeks or lips	☐	☐	Clenching or grinding
☐	☐	Clicking/popping jaw	☐	☐	Change in bite
☐	☐	Difficulty open/close jaw	☐	☐	Shift in bite

Do you use any of the following:

Yes	No		Yes	No	
☐	☐	Manual toothbrush	☐	☐	Dental floss
☐	☐	Electric toothbrush	☐	☐	Waterpik
☐	☐	Mouthwash	☐	☐	Toothpaste for sensitive teeth

Smile guide

Yes	No		
☐	☐	Do you like your smile?	Rank your smile from **1 2 3 4 5 6 7 8 9 10**
☐	☐	Do you like the color of your teeth?	1= very unhappy 10= very happy
☐	☐	Do you like the position of your teeth?	What do you think can be done to make your teeth a 10?
☐	☐	Do you like the shape of your teeth?	_____