Name:

Pine Street DENTAL

Patient Dental History:

Previous Dentist: _____ **Phone:**_____

Last Dental Visit:_____ **Last Date of X-Rays:**_____

Have you ever had any of the following? Please circle answers below:

Bad Breath	Cigar/ Cigarette Smoking	Clicking or Popping of Jaw
Bleeding Gums	Food Collection between teeth	Gums swollen or tender
Loose teeth	Broken fillings	Sensitivity to Hot or Cold
Sore or growths in mouth	Lip or check biting	Sensitivity when chewing or biting

Have you ever injured or sustained any form of trauma to the following? (Please circle all that apply)

Head Neck Jaw

Have you ever had Periodontal Treatment?: Yes No **Date of Treatment?:**_____

Have you ever had Orthodontic Treatment?: Yes No **Date Treatment Began:**_____

Were third molar/wisdom teeth removed?: Yes No **Date of Surgery:**_____

Do you use bleaching/whitening products on your teeth?: Yes No **What brand?:**_____

Have you ever have TMJ problems?: Yes No

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE?

_____

_____

Daily Home Care Habits:

What type of toothbrush do you use? Manual Electric **If Electric, what type:**_____

How often do you floss?_____

Do you use a Waterpik? Y N

Please list any additional dental products used:

_____

_____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian:_____ **Date:** _____