Camino Dental Group

1328 W. El Camino Real Ste #1, Mountain View CA 94040 Tel (650) 962-8773 Fax (650) 962-8464

Today's Date _____________

Patient Information

Patient Name ____ ________________
Last First Preferred Name

Date of birth _____________ Gender ☐ M ☐ F Marital Status ________ Driver's license no ______________

Address _________________________ Ste or Apt # _____ City ________________ State _____ Zip __________

If patient is minor (age 18 or below, go to Minor Patient Information)

Main contact (**please check one**) ☐ Cell ☐ Home ☐ Work Best time to call ____________

Home Phone (____) ______________ Cell (____) _______________ Email ______________________________

Employer _________________________ Work Phone (____) _____________ Occupation _________________

Spouse's name ______________________ Spouse's Employer _____________________ Number of children _____

Minor Patient Information

Please check main contact →	☐ Mother/Guardian	☐ Father/Guardian
Name		
Employer		
Occupation		
Home Phone Number		
Cell Phone Number		
Work Phone Number		
Email		

Emergency contact person (other than spouse) ___________________ Relationship ____________Phone: ______________

How did you hear about us? ☐ Internet ☐ Yellow Pages ☐ Insurance Listings ☐ Referred by _________________________

Dental History

Have you ever had the following?

- ☐ Wisdom teeth removal
- ☐ Orthodontic Treatment (braces)
- ☐ Gum Surgery
- ☐ Dental Implants
- ☐ Cosmetic Crowns/Veneers
- ☐ Dental complications
- ☐ Bad reaction to local anesthetic or dental products
- ☐ Grinding or clenching teeth
- ☐ Jaw or muscle discomfort
- ☐ Wearing (please circle) denture mouth guard retainers

Home Care:

How often do you brush? ____________

How often do you floss? ____________

Dental products used:

- ☐ Power toothbrush ___________
- ☐ Water irrigator (Waterpik)
- ☐ Perioaid/gum stimulator
- ☐ Proxy brush
- ☐ Mouth rinse ______________
- ☐ Whitening products ____________________
- ☐ Desensitizing paste __________

Are you currently having?

- ☐ Bleeding gums
- ☐ Sensitive teeth/gums
- ☐ Toothache – mild moderate severe
  Location: ________________

Please check if interested:

- ☐ Whitening teeth
- ☐ Straightening teeth
- ☐ Restoring missing teeth (implants)
- ☐ Cosmetic crowns/veneers
- ☐ Mouth guard (for sleep apnea, grinding/clenching, or snoring)

Date of last dental exam:

Date of last dental cleaning:

Date of last full mouth x-rays:

Reason for today's visit

Please describe any special circumstance about your past dental treatment or history that you would like us to know.