

Camino Dental Group

1328 W. El Camino Real, 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 →	<input type="checkbox"/> Mother/Guardian	<input type="checkbox"/> Father/Guardian
Name		
Employer		
Occupation		
Home Phone Number		
Cell Phone Number		
Work Phone Number		
Email		

Person to notify in case of emergency _____ 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
- 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
 - Receding gums
 - Sensitive teeth
 - Toothache – mild moderate severe
 - Bad Breath
 - Jaw or muscle discomfort
- Please check if interested:
- Whitening teeth
 - Straightening teeth
 - Restoring missing teeth (implants)
 - Cosmetic crowns/veneers
 - Mouth guard (if you play sports)

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.