CAMBRIDGE DENTAL
STUDIO

409 Cambridge Ave. Suite A
Palo Alto, CA 94306
(650) 382-3068

Today's Date_____

Name *(Last, First, M.I.):* ☐ **M** ☐ **F**	**DOB:**
How do you wish to be addressed?	**SSN:**

Marital status: ☐ Single ☐ Domestic Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

How did you hear about us? ☐ Online (Google, Yelp, Website)
☐ Family/Friend Referral If so, whom may we thank for the referral_____
☐Insurance Referral ☐Other_____

Home Address Street: _____ City: _____ State: _____ Zip Code: _____	**Mailing Address** Street: _____ City: _____State: _____ Zip Code: _____
Home Phone: ( ) **Cell Phone: ( )**	**Work Phone: ( )** **Email: @**

Employer: **How Long?** _____

Spouse's Name *(Last, First, M.I.):*	Spouse's DOB:
Spouse's Employer	Spouse's SSN:

Who to notify in case of emergency: **Phone number: ( )**

Primary Dental Insurance	**Secondary Dental Insurance**
Employee name: _____	Employee name: _____
Date of Birth: _____ SSN: _____	Date of Birth: _____ SSN: _____
Employer: _____	Employer: _____
Name of Insurance Company: _____	Name of Insurance Company: _____
Insurance Address: _____ _____	Insurance Address: _____ _____
Phone Number: ( )	Phone Number: ( )
Insurance ID Number: _____	Insurance ID Number: _____
Group Number: _____	Group Number: _____

Dental History

What is the purpose of this visit?	
Do you have a specific dental problem that needs attention now? If so, what is it?	
Do you need to pre-medicate prior to dental appointments? ☐ **Y** ☐ **N**	
What is the date of your last dental visit?	What is the date of your last dental cleaning?
Have you had dental x-rays taken within the last 5 years?	

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Who was your previous dentist?	
Address & Phone Number:	
Do you clench or grind your teeth? ☐ Y ☐ N	Does your jaw click or pop? ☐ Y ☐ N
Have you experienced any pain or soreness in the muscles of your face or ear? ☐ Y ☐ N	
Does food get caught between your teeth? ☐ Y ☐ N	Are any of your teeth sensitive to ☐ heat ☐ cold ☐ pressure ☐ sweets?
How often do you brush your teeth?	How often do you floss?
Do your gums bleed or hurt when brushing or flossing? ☐ Y ☐ N	Has anyone told you your breath is offensive? ☐ Y ☐ N
Have you previously had gum surgery? ☐ Y ☐ N	Have you been treated for periodontal disease? ☐ Y ☐ N
Are you happy with the appearance of your teeth? ☐ Y ☐ N	Have you had any unpleasant dental experiences? ☐ Y ☐ N
Do you have any questions or concerns?	

Medical History

When was your last complete physical exam? Reason?

Physician's Name & Phone Number:

Have you been hospitalized in the last 5 years? ☐ Y ☐ N Reason:

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Drug Name	Strength	Frequency

Have you ever taken Fosamax or any other osteoporosis medications? ☐ Y ☐ N

Are you allergic to or had an adverse reaction to any medication, including penicillin? ☐ Y ☐ N

Are you allergic to anesthetic or latex? ☐ Y ☐ N	Have you ever been diagnosed with sleep apnea? ☐ Y ☐ N

Please check ALL answers, yes OR no. Do you have or have you been treated for, or told you might have:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Artificial Joint	☐	☐	Low Blood Pressure	☐	☐	Kidney Disease	☐	☐	Anemia
☐	☐	Heart Valve Disease	☐	☐	Stroke	☐	☐	Jaundice	☐	☐	Respiratory Disease
☐	☐	Heart Disease	☐	☐	Radiation Treatment	☐	☐	Herpes 1	☐	☐	Fainting Spells
☐	☐	Rheumatic Fever	☐	☐	Cancer	☐	☐	Herpes 2	☐	☐	AIDS
☐	☐	Heart Murmur	☐	☐	Asthma	☐	☐	Epilepsy	☐	☐	Menopause
☐	☐	Mitral Valve Prolapse	☐	☐	Hives	☐	☐	Arthritis	☐	☐	Sleep Apnea
☐	☐	High Blood Pressure	☐	☐	Diabetes	☐	☐	Tuberculosis	☐	☐	Hepatitis Type: _____ When:_____

Are you pregnant? ☐ Y ☐ N	Do you smoke? ☐ Y ☐ N	Do you consume alcoholic beverages? ☐ Y ☐ N

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Have you ever bled excessively after being cut or wounded? ☐ Y ☐ N	Have you ever tested positive for the AIDS antibody? ☐ Y ☐ N
Have you ever had any other serious medical problem? ☐ Y ☐ N	Explain:
Is there anything else we should know about your health?	

Authorization & Release

I have read and answered the above questions to the best of my knowledge; I authorize & request my insurance company to pay the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of patient Date