ZOKA Orthodontics
3801 Las Posas Road, Suite 212
Camarillo, CA 93010
(805) 482-6636

X-RAY _____ DATE _____ TIME

DATE OF 1ST EXAM
MONTH | DAY | YR

GETTING TO KNOW YOU!

ADULT

A. GENERAL INFORMATION

1) Last Name

2) First

LAST NAME (PLEASE PRINT) | FIRST | MIDDLE INITIAL | SEX M F | AGE (YRS & MOS) | PATIENT'S BIRTHDATE

HOME PHONE # | STATUS SINGLE ☐ MARRIED ☐ DIVORCED ☐

PATIENT'S ADDRESS | STREET | CITY | STATE | ZIP CODE

EMPLOYED BY | JOB TITLE | HOW LONG? | PHONE # AT WORK

INSURANCE | GROUP # | FAX/BEEPER # | SS # - -

SPOUSE'S NAME — LAST | FIRST | MIDDLE INITIAL

SPOUSE'S EMPLOYER | JOB TITLE | HOW LONG? | PHONE # AT WORK

INSURANCE | GROUP # | FAX/BEEPER # | SS # - -

PERSON RESPONSIBLE FOR ACCOUNT: | PRIMARY INSURANCE — IF DUAL COVERAGE

HOW DID YOU FIRST HEAR ABOUT OUR OFFICE?

PATIENT'S DENTIST — NAME | ADDRESS | CITY & ZIP | PHONE #

PERSON (NOT LIVING WITH YOU) TO CONTACT IN CASE OF EMERGENCY
NAME: | RELATIONSHIP: | ADDRESS: | PHONE:

ANY FAMILY/FRIENDS TREATED AT OUR OFFICE:

NOW COMPLETE B AND C. ENCIRCLE OR UNDERLINE CONDITIONS IF YES (FEEL FREE TO USE THE OTHER SIDE FOR ADDITIONAL REMARKS OR INFORMATION

B. MEDICAL HISTORY

	YES	NO
1. RHEUMATIC FEVER CONGENITAL HEART DISEASE	☐	☐
2. HEART MURMUR	☐	☐
3. ALLERGIES: A) FOOD, DUST, ETC.	☐	☐
B) DRUG, i.e. Penicillin, etc.	☐	☐
C) UNKNOWN	☐	☐
4. ASTHMA OR HAY FEVER	☐	☐
5. ARTHRITIS OR RHEUMATISM (PAINFUL SWOLLEN JOINTS)	☐	☐
6. DIABETES OR BLOOD SUGAR PROBLEMS	☐	☐
7. ANY PROLONGED BLEEDING OR BRUISES EASILY	☐	☐
8. DO YOU NEED TO BE PRE MEDICATED WHY:	☐	☐
ALLERGIC TO LATEX:	☐	☐
RADIATION THERAPY?	☐	☐
9. ANEMIA OR BLOOD DISORDERS	☐	☐
10. TUBERCULOSIS OR PNEUMONIA	☐	☐
11. LIVER PROBLEMS, JAUNDICE OR HEPATITIS	☐	☐
12. GLANDULAR OR HORMONAL PROBLEMS	☐	☐
13. ACCIDENTS OR SEVER INFECTIONS	☐	☐
14. CONVULSION, SEIZURES, FAINTING OR EPILEPSY	☐	☐
15. HIGH/LOW BLOOD PRESSURE	☐	☐
16. SPEECH, LEARNING OR HEARING DISORDERS	☐	☐
17. CHILDHOOD ILLNESSES	☐	☐
18. IMMUNIZATIONS	☐	☐
19. HIV AIDS	☐	☐
20. OTHER — EXPLAIN		
21. REHABILITATION (DRUGS/ALCOHOL)	☐	☐
22. KIDNEY/BLADDER PROBLEMS	☐	☐

	YES	NO
OPERATED ON FOR	☐	☐
BEEN HOSPITALIZED FOR	☐	☐
ALLERGIES OR DRUG REACTION TO	☐	☐
POLIO, MONO, TUBERCULOSIS, PNEUMONIA	☐	☐
RHEUMATIC FEVER—A HEART CONDITION— 'RHEUMATISM'	☐	☐
INSOMNIA OR 'HYPERACTIVE' CONDITION, MUSCLE OR BACK PAIN	☐	☐
A NERVOUS BREAKDOWN — PSYCHOLOGIC, EMOTIONAL CONDITION	☐	☐
A TENDENCY TO CRY OR GET UPSET EASILY	☐	☐
SEVERE HEADACHES,	☐	☐

MEDICAL INSURANCE _____
PATIENT UNDER PHYSICIAN'S CARE, FOR _____
PATIENT UNDER MEDICATION? PLEASE NAME IT _____
PHYSICIAN NAME: _____
PHONE NO. _____

C. DENTAL HISTORY

	YES	NO
BABY TEETH REMOVED THAT WERE NOT LOOSE	☐	☐
CHIPPED OR OTHERWISE INJURED BABY OR PERMANENT TEETH	☐	☐
PERMANENT OR "EXTRA" TEETH REMOVED	☐	☐
TEETH SENSITIVE TO HOT OR COLD. TEETH THROB OR ACHE	☐	☐
JAW FRACTURES — CYSTS — ABSCESS — OTHER INFECTIONS	☐	☐
'DEAD TEETH' — ROOT CANALS TREATED	☐	☐
BLEEDING GUMS — BAD TASTE — MOUTH ODOR	☐	☐
GINGIVITIS — 'VINCENTS' INFECTION — 'POCKETS'	☐	☐
FOOD IMPACTION BETWEEN TEETH — PERIODONTAL PROBLEM	☐	☐
'GUM BOILS' — FREQUENT CANKER SORES — 'COLD SORES'	☐	☐
LIP-CHEEK-TONGUE BITING — SORENESS, OR BLEEDING	☐	☐
THUMB, FINGER, TONGUE-SUCKING HABIT UNTIL AGE	☐	☐
ABNORMAL SWALLOWING HABIT (TONGUE THRUSTING) TO AGE	☐	☐
NAIL BITING HABIT TO AGE /MOUTH-BREATHING HABIT	☐	☐
TOOTH-GRINDING	☐	☐
DIFFICULTY ENCOUNTERED IN BREATHING, CHEWING	☐	☐
PRESENTLY MISSING TEETH	☐	☐
AWARE OF LOOSE, BROKEN OR MISSING RESTORATIONS (FILLINGS)	☐	☐
ANY TEETH IRRITATING CHEEK — LIP — TONGUE — PALATE	☐	☐

1. WHAT IS YOUR MAIN CONCERN? _____

2. HAVE YOU HAD PREVIOUS ORTHODONTIC TREATMENT? _____

WHEN? _____ WITH DR. _____

3. DO YOU HAVE ANY PROBLEMS WITH YOUR JAWS? CLICKING? LOCKING? PAIN?
☐ YES ☐ NO

4. HAVE YOUR WISDOM TEETH BEEN REMOVED? _____

5. HAVE YOU HAD PERIODONTAL OR GUM PROBLEMS? _____

IT IS MY RESPONSIBILITY TO ADVISE THIS OFFICE OF ANY CHANGE IN PERSONAL OR MEDICAL STATUS.
PLEASE SIGN THAT THIS INFORMATION IS ACCURATE AND COMPLETE.

SIGNATURE _____

RECEIVED BY DR. _____ DATE _____