Personal Info Sheet

Dr. McClurg's Smile Center

Office:__________ Date:__________

Patient Info

Name: ______________________ (first / mi / last)

SS No: __________

Email: __________

Address: __________

City: __________ State:______ Zip:______

H Phone: __________ W Phone:__________

Birthday: __________ Age:______ Sex:______

Other Children:__________ Birthday:__________

Other Children:__________ Birthday:__________

Other Children:__________ Birthday:__________

Dentist: __________

Dentist's Phone: __________

Dentist's Address: __________

____

Emergency Name: __________

Emergency Phone: __________

Who may we thank for referring you?

Advertisement: TV______ Radio______ Coupon______

Newspaper/Magazine:__________

Friend: __________

Insurance Co.: __________

1st Responsible Party Info

(Person responsible for payment on account)

❑ Self ❑ Spouse ❑ Mother ❑ Father ❑ Other

Name: ______________________ (first / mi / last)

SS No: __________

Email: __________

Address: __________

City: __________ State:______ Zip:______

H Phone: __________ W Phone:__________

Birthday: __________ Age:______ Sex:______

EMPLOYER INFORMATION

Name: __________

Address: __________

City: __________ State:______ Zip:______

DENTAL INSURANCE COMPANY

Orthodontic Coverage? ☐Y ☐N

Name: __________

Address: __________

City: __________ State: ______ Zip:______

Phone: __________

Group No:__________ Local / Union No:__________

2nd Responsible Party Info

(Person responsible for payment on account)

❑ Self ❑ Spouse ❑ Mother ❑ Father ❑ Other

Name: ______________________ (first / mi / last)

SS No: __________

Email: __________

Address: __________

City: __________ State:______ Zip:______

H Phone: __________ W Phone:__________

Birthday: __________ Age:______ Sex:______

EMPLOYER INFORMATION

Name: __________

Address: __________

City: __________ State:______ Zip:______

DENTAL INSURANCE COMPANY

Orthodontic Coverage? ☐Y ☐N

Name: __________

Address: __________

City: __________ State:______ Zip:______

Phone: __________

Group No: __________ Local / Union No:__________

SACRAMENTO
916 381-7171
8689 Folsom Blvd.
95826

ROSEVILLE
916 771-4884
106 N. Sunrise Blvd.
Suite C-8 95661

PLACERVILLE
530 626-3000
4363 Golden Center Dr.
95667

MODESTO
209 238-9700
1212 12th St.
95354

e-MAIL:
info@ drmcclurg.com

WEB SITE:
www.drmcclurg.com

Health Data Sheet

Health History Form Updated

Int. ____________
Date ____________

Int. ____________
Date ____________

Int. ____________
Date ____________

Int. ____________
Date ____________

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Medical History

	YES	NO
Any heart disease:		
Any respiratory disease:		
Any blood disease:		
Any liver disease:		
Any thyroid disease:		
Any kidney disease:		
H.I.V. positive:		
Any venereal disease:		
Any intestinal disease:		
Any bone disease:		
Any nervous/emotional problems:		
Any high or low blood pressure:		
Any endocrine problems:		
Any problem with wounds healing:		
Rheumatic/yellow/scarlet fever:		
Acquired Immune Deficiency Syndrome:		
Is patient under medical care:		
Rheumatism or arthritis:		
Is patient taking any medications:		
A history of fainting or dizziness:		
Headaches:		
Does patient have a drug addiction:		
Is patient pregnant at this time:		
Measles/mumps/chicken pox:		
Does patient smoke:		
Is the patient in good health:		
Is height and weight normal for age:		
Has patient ever had fever blisters:		
Has patient had a physical this year:		
Has patient reached puberty:		
Heart murmur:		
Mononucleosis:		
Hepatitis:		
Polio:		
Diabetes:		
Anemia:		
Hemophilia:		
Emphysema:		
Epilepsy:		
Asthma or hay fever:		
Tuberculosis:		
Had any broken bones:		
Prolonged bleeding:		
Yellow jaundice:		
Radiation therapy:		
Chemical therapy:		
Blood transfusions:		
Is the patient allergic to anything:		

If so, what:

List any medications taken in last 90 days:

Are you aware of any other disease, condition, or problem not listed above that we should know about? If yes, what:

Dental History

	YES	NO
Has the mouth, face or teeth been injured by a fall or accident:		

If so, when:

	YES	NO
Has the patient seen a general dentist in the last year:		
Any pain, clicking or discomfort in or near the ears:		
Is the patient experiencing TMJ problems:		
Have you been informed of missing or extra permanent teeth:		
Are you aware of any "gum" problems:		
Has a physician or dentist advised antibiotics before a dental exam:		
Have the patient's tonsils or adenoids been removed:		
Do you feel the patient can benefit from orthodontic treatment:		
Is the patient happy with their "SMILE":		
Does the patient want to improve their "SMILE" and "BITE":		
Would the patient mind wearing "BRACES":		

Does the patient have or ever had any of the following habits

	YES	NO
Cheek, tongue or lip chewing:		
Thumb sucking:		
Mouth breathing:		
Finger nail biting:		
Clenching teeth:		
Tongue thrusting:		
Grinding teeth:		
Speech problems:		

Orthodontic treatment history

	YES	NO
Has the patient been examined by an orthodontist before:		
Have other family members had orthodontic treatment:		
If yes, were you happy with the results:		

If no, why:

In your own words what is the orthodontic problem:

What would you like the orthodontic treatment to accomplish:

Signatures

patient — date

responsible party — relationship to patient — date

doctor — date

office witness — date