Brickyard
Dental Clinic

Medical Alert

In an effort to serve you better, we ask that you complete the following. We will be glad to assist you. Please Print Clearly.

Patient Information

A Parent or Guardian will be responsible for decisions on my treatment: Yes ◯ No ◯

Name: ______________________ First ______________________ Initial ______________________ Last

Preferred Name ______________________

Address: ______________________ Street ______ Apt. ______________________ City ______ Prov. ______ Postal Code ______

Date of Birth ____ M ____ D ____ Y

Home Tel: (______) ______________________ Work Tel: (______) ______________________

Gender: Male ◯ Female ◯ Cell: (______ Email: ______________________

Emergency Contact ______________________ Contact's Phone: (______

Family Doctor: ______________________ Dr.'s Phone: (______

Financial Information

Person responsible for financial matters: Self ◯ Spouse ◯ Parent/Guardian ◯ Other ◯

Primary Insurance

Ins. Company: ______________________ Insurance Details: ______________________

Employer/Policy Holder: ______________________

Policy #: ______________________ Certificate #: ______________________

Max Cov.: ______________________ % Coverage for: Basic ______ Maj. Restorative ______ Orthodontic ______

Secondary Insurance

Ins. Company: ______________________ Insurance Details: ______________________

Employer/Policy Holder: ______________________

Policy #: ______________________ Certificate #: ______________________

Max Cov.: ______________________ % Coverage for: Basic ______ Maj. Restorative ______ Orthodontic ______

Dental History

1. What is the reason for your visit today? ◯ Emergency ◯ Examination ◯ Other ______________________
2. How frequently do you visit a dentist? ◯ 3-6 months ◯ Annually ◯ Other ______________________
3. When was your last dental visit? ______________________ Last X-ray? ______________________
4. How often do you brush per day? ______ Floss? ______ Use Anti-bacterial rinse? ______
5. Are your teeth sensitive to: ☐ Cold ☐ Heat ☐ Sweets ☐ Other ______________________
6. Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Never ☐ Other ______________________
7. Do your jaws crack, pop or grate when you open widely? .... Yes ◯ No ◯
8. Do you regularly grind or clench your teeth? .... Yes ◯ No ◯
9. Have you ever had any problems with previous dental treatments? Specify ______________________
10. Have you ever had any of the following? ☐ Bridgework ☐ Crowns or Caps ☐ Full or Partial Dentures ☐ Orthodontic (braces) ☐ Periodontal (Gum Surgery) ☐ Root Canal