NATHAN BROTT DDS

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Date: _____

Name: _____ I like to be called: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail address: _____ Social Security #: _____

Occupation: _____ Employer: _____

Home Telephone: _____ Work: _____ Cell: _____

Who can we thank for referring you? _____

Special interests or hobbies? _____

In case of emergency, who can we call? _____ Phone: _____

Do you have Dental Insurance? Yes ❑ No ❑ Name of Insurance: _____

Subscriber's name: _____ Birthdate: _____

ID #: _____ Group #: _____

Physician: _____ Phone: _____

Last visit with physician: _____ Significant findings? _____

Have you had any serious medical problems within the past 5 years? Yes ❑ No ❑ If yes, please explain: _____

Do you need to premedicate before dental treatment? Yes ❑ No ❑ If yes, please explain: _____

Are you currently taking prescription medications? Yes ❑ No ❑ If yes, please explain: _____

Have you ever had or been treated for any of the following diseases or medical problems?

Heart Disease	Yes ❑ No ❑	Rheumatic Fever	Yes ❑ No ❑	Stroke	Yes ❑ No ❑
Hepatitis/Jaundice	Yes ❑ No ❑	High Blood Pressure	Yes ❑ No ❑	Cardiac Pacemaker	Yes ❑ No ❑
Epilepsy/Seizures/Fainting	Yes ❑ No ❑	Abnormal Bleeding	Yes ❑ No ❑	Joint/Valve Replacement	Yes ❑ No ❑
Cancer/Chemotherapy	Yes ❑ No ❑	Kidney Disease	Yes ❑ No ❑	Thyroid Problems	Yes ❑ No ❑
Psychiatric Problem	Yes ❑ No ❑	Diabetes	Yes ❑ No ❑	Previous Endocarditis	Yes ❑ No ❑
Tuberculosis	Yes ❑ No ❑	Drug/Alcohol Abuse	Yes ❑ No ❑	Ever taken Fosamax,	Yes ❑ No ❑
AIDS/HIV	Yes ❑ No ❑	Anemia	Yes ❑ No ❑	Boniva, or Fen-Phen	Yes ❑ No ❑
Heart Murmur	Yes ❑ No ❑	Stroke	Yes ❑ No ❑		

Have you been treated for any other illnesses not listed above? Yes ❑ No ❑ If yes, please explain: _____

Are you allergic to any of the following medications?

Penicillin Yes ❑ No ❑ Aspirin Yes ❑ No ❑ Dental Anesthetic Yes ❑ No ❑

Erythromycin Yes ❑ No ❑ Codeine Yes ❑ No ❑

Are you allergic to any other medications? Yes ❑ No ❑ If yes, please explain: _____