NATHAN BROTT DDS

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Date: _____

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

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

E-mail address: _____

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: _____ Subscriber's Birthdate: _____

ID#: _____ Group#: _____

Social Security #: _____

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 and give date of surgery:

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? *(circle and check applicable)*

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

DENTAL HISTORY

What prompted you to come see us? _____

_____

_____

What are you looking for in a dentist and a dental office? _____

_____

_____

Are you currently in pain or discomfort with your teeth or gums? _____

_____

_____

How would you describe the condition of your teeth and gums? Good _____ Fair _____ Poor _____
Please explain : _____

_____

Have you ever had a negative dental experience that you would like to share with us? _____

_____

_____

_____

Do you have concerns about the appearance of your teeth? _____

_____

_____

Is it important to you to eliminate future dental problems? Definitely _____ Not really _____
Please explain : _____

_____

Have you ever been treated for TMJ symptoms? If yes, please explain: _____

_____

_____

_____

What can we do to make your experience with us as pleasant as possible? _____

_____

_____

_____

If you could easily and safely whiten your teeth, would you be interested? Yes _____ No _____

I understand that the information is correct and to the best of my knowledge. I understand it will be held in the strictest confidence and only be used to improve communication between the doctor and myself.

I understand that the responsibility for payment for dental services provided in this office for myself and/or my dependents is mine, due and payable at the time services are rendered. I further understand that 1.5% service change (18% annually) will be added to any balance over 30 days. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this debt. Should I request credit for dental treatment, I consent to a credit check.

Patient's Signature _____ Date _____

Responsible Party (if patient is a minor) _____ Date _____