

DR. DAVID W. BRANCH, D.D.S.

Family Dentistry in Downtown Seattle

Click TAB
to move your cursor
to the next form field.

Date _____
(mm/dd/yyyy)

Name _____ SS# _____ Birth Date _____
(mm/dd/yyyy)

Home Phone _____ Cellular Phone _____ Email _____

Address _____

City, State, Zip Code _____

Employer _____ Occupation _____ Work Phone _____

Insurance _____ Group # _____ ID # _____

Spouse Name _____ SS# _____ Birth Date _____
(mm/dd/yyyy)

Employer _____ Work Phone _____

Insurance _____ Group # _____ ID # _____

Referred by _____

MEDICAL HISTORY

1. Are you in good health? Yes No
2. Have there been any changes in your health in the past year? Yes No
3. My last physical examination was on: Date _____ At _____
4. Are you under the care of a physician for any specific health issue? Yes No
Name of Physician _____ Phone Number _____
5. Have you had any serious illnesses, operations, hospitalizations, x-ray or drug treatment for tumor growth or any other condition? Yes No
If yes, please explain _____
6. Are you taking any over the counter or prescription drugs? Yes No
If yes, what? _____
7. Are you taking any of the following:
 - a. Anticoagulants (blood thinners) Yes No
 - b. Antibiotics or sulfa drugs Yes No
 - c. Medicine for high blood pressure Yes No
 - d. Cortisone or any steroids Yes No
 - e. Tranquilizers Yes No
 - f. Antihistamines Yes No
 - g. Aspirin Yes No
 - h. Insulin, tolbutamide (Orinase) or similar drug Yes No
 - i. Digitalis or drugs for heart trouble Yes No
 - j. Nitroglycerin Yes No
 - k. Other _____

8. Do you have or have you had any of the following diseases or problems?

- a. Damaged or artificial heart valves, heart murmur. Yes No
- b. Congenital heart lesions Yes No
- c. Heart trouble, heart attack, stroke . . . Yes No
- d. Rheumatic fever Yes No
- e. High blood pressure Yes No
- f. Cardiac pacemaker Yes No
- g. Allergies Yes No
- h. Sinus trouble Yes No
- i. Respiratory problems (asthma, emphysema, chronic bronchitis, TB) . . Yes No
- j. Seizures Yes No
- k. Diabetes Yes No
- l. Hepatitis, jaundice or liver disease . . . Yes No
- m. Arthritis Yes No
- n. Artificial joints Yes No
- o. Stomach ulcers Yes No
- p. Multiple sclerosis Yes No
- q. Low Blood pressure Yes No
- r. Epilepsy Yes No
- s. Psychiatric problems Yes No
- t. Cancer Yes No
- u. AIDS or other immunosuppressive disorders Yes No
- v. Abnormally long bleeding time or bruise easily Yes No
- w. Blood transfusions. Yes No
- x. Blood disorders, anemia Yes No
- y. Herpes Yes No
- z. asthma. Yes No

Notes

9. Are you allergic or have you reacted adversely to:

- a. Local anesthetics (Novocaine, etc) . . . Yes No
- b. Penicillin or other antibiotics. Yes No
- c. Sulfa drugs Yes No
- d. Barbiturates, sedatives, or sleeping pills Yes No
- e. Aspirin Yes No
- f. Iodine Yes No
- g. Codeine or other narcotics. Yes No
- h. Sulfites. Yes No
- i. Latex Yes No
- j. Dogs Yes No
- k. Other Yes No

10. Do you have any disease, condition or problem not listed above that you think we should know about?

11. Have you had any trouble associated with any previous dental treatments?

12. When were you last seen by a dentist? _____

Name of previous dentist? _____

13. Do you still have your 3RD molars (wisdom teeth)? Yes No

14. Have you ever used tobacco products? Yes No

How much? _____

15. How well do you like your smile? Love it It's OK I don't like to show my smile

16. Is there anything you would change about your smile?

17. Women only:

a. Are you taking oral contraceptives or other hormonal therapy? Yes No

b. Are you pregnant? Yes No

I certify that I have read and understand the above. I hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursement, directly to the doctor, of insurance benefits under which I am entitled. I will not hold my dentist, or any other members of his staff, responsible for any errors or omission that I may have made in the completion of this form.

Your signature below will authorize the office of Dr. David Branch to release your dental x-rays, clinical chartings and records to your insurance provider and/or other licensed health care providers.

Signature _____

Please PRINT, SIGN and BRING this completed form with you to your first appointment. Thank you!