Please fill out this form completely. The better we communicate, the better we can care for you.

Babylon Dental Care

GREAT SOUTH BAY GATEWAY PLAZA

Tel: 631-983-6665 • Fax: 631-635-5309 • www.babylondentalcare.com

MEDICAL HISTORY

Name: _____ D.O.B. _____

Home # _____ Cell # _____

Home Address: _____

Email Address: _____

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone # _____

Date of last visit: _____

Are you currently under the care of a physician?

☐ Yes ☐ No

Please explain: _____

_____

Are you taking any prescription or over-the-counter drugs?

Please list each one: _____

_____

_____

_____

Pharmacy Name: _____

Pharmacy Ph # _____

Are you taking any medication for bone strength,

☐ Yes ☐ No

such as: ☐ Fosamax ☐ Boniva ☐ Actonel

☐ Other _____

Do you smoke or use tobacco? ☐ Yes ☐ No

Are you allergic to any of the following? ☐ Yes ☐ No

__ Aspirin __ Penicillin __ Codeine

__ Tetracycline __ Latex __ Erythromycin

__ Dental Anesthetics __ Jewelry / Metals __ Other _____

Have you been diagnosed with Obstructive Sleep Apnea?

☐ Yes ☐ No

Do you currently wear a CPAP device? ☐ Yes ☐ No

FOR WOMEN:

Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

If yes, how many weeks? _____

Are you nursing? ☐ Yes ☐ No

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

__ Abnormal Bleeding
__ Allergies
__ Anemia
__ Artificial Bones / Joints
__ Artificial Valves
__ Asthma
__ Blood Transfusion
__ Cancer
__ Chemotherapy
__ Congenital Heart Defect
__ Diabetes
__ Difficulty Breathing
__ Drug / Alcohol Abuse
__ Emphysema
__ Epilepsy / Seizures
__ Fainting Spells
__ Fever Blisters / Herpes
__ Glaucoma
__ Heart Attack / Stroke
__ Heart Murmur
__ Heart Surgery / Pacemaker
__ Hemophilia/Abnormal Bleeding
__ Hepatitis
__ High / Low Blood Pressure
__ HIV + / AIDS
__ Hospitalized for Any Reason
__ Kidney Problems
__ Mitral Valve Prolapse
__ Psychiatric Problems
__ Radiation
__ Rheumatic / Scarlet Fever
__ Severe / Frequent Headaches
__ Shingles
__ Sinus Problems
__ Tuberculosis (TB)
__ Ulcers / Colitis
__ Venereal Diseases

SERIOUS MEDICAL CONDITION(S):

Please list any serious medical condition(s) that you have ever had: _____

_____

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ _____

Signature Date

If under 18, Parent / Guardian Signature required

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.