BABYLON DENTAL CARE of Great South Bay

Treating people like family for over 30 years!
Our goal is to help you reach and maintain your maximum oral health.
Please fill out this form completely.
The better we communicate, the better we can care for you.

Babylon Dental Care of Great South Bay
785 West Montauk Highway, West Babylon NY 11704
Tel: 631.587.7373 • Fax: 631.587.7398 • www.babylondentalcare.com

MEDICAL HISTORY

Name:_____D.O.B._____

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? ☐ Yes ☐ No

Please list each one:_____

_____

_____

_____

Are you taking any medication for bone strength,

☐ Yes ☐ No

such as: ☐ Fosamax ☐ Boniva ☐ Actonel ☐

Other_____

Do you smoke or use tobacco in any form?

☐ Yes ☐ No

Do you use chewing tobacco? ☐ Yes ☐ No

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

__Asprin	__Penicillin	__Codeine
__Tetracycline	__Latex	__Erythromycin
__Dental Anesthetics	__Jewerly/metals	__Other_____

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 this 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.