Welcome To Our Office!

Please fill out this information as completely as possible. Thank you!

North Babylon Dental Associates, LLP
837 Deer Park Ave.
North Babylon, NY 11703

Name (Dr., Mr., Mrs., Ms.): _____ Home Phone: _____

If Child, name of parent: _____ Bus. Phone: _____

Address: _____ E-Mail Address: _____

Town. State, Zip: _____ Spouse's Name: _____

Date Of Birth: _____ Spouse's Occupation: _____

S.S.# _____ Employed By: _____

Occupation: _____

Employed By: _____ Referred By: _____

Dental Insurance (Primary): _____

Dental Insurance (Secondary): _____ D.O.B.: _____ S.S.#: _____

Medical History *(Please answer all questions)*

Have you ever had any of the following...

Yes	No		Yes	No		Yes	No	
_____	_____	Angina	_____	_____	Cancer	_____	_____	Any Anesthetics
_____	_____	Heart Attack	_____	_____	Diabetes	_____	_____	Aspirin
_____	_____	Heart Murmur	_____	_____	Epilepsy	_____	_____	Codeine
_____	_____	High Blood Pressure	_____	_____	Hepatitis / Liver Disease	_____	_____	Erythromycin
_____	_____	Mitral Valve Prolapse	_____	_____	Joint Replacement	_____	_____	Latex
_____	_____	Pacemaker	_____	_____	Kidney Disease	_____	_____	Penicillin
_____	_____	Prosthetic Heart Valves	_____	_____	Sinus Problem	_____	_____	Tetracycline
_____	_____	Rheumatic Fever	_____	_____	Thyroid Disease	_____	_____	Other: _____
_____	_____	Other Heart Condition	_____	_____	Ulcer			_____
_____	_____	Lung Disease / Asthma	_____	_____	AIDS / HIV Positive			_____
_____	_____	Tuberculosis	_____	_____	Herpes			
_____	_____	Anemia	_____	_____	Venereal Disease			
_____	_____	Excessive Bleeding	_____	_____	Other: _____			

Do you have any known allergies to...

Date of last physical exam: _____

Please list all medications taken: _____

_____

Your Physician's name & phone: _____

Are you being treated for any condition currently? (Please explain): _____

Have you been hospitalized in the last 5 years? (Please explain): _____

Have you ever responded unfavorably to medical or dental care? (Please explain): _____

_____

Women: Are you pregnant? ____ yes ____no

Women: Are you using birth control pills? ____ yes ____no (certain medications may interfere)

Dental History

Are you having dental pain? ____ yes ____no

Date of last dental examination: _____

Have you ever had any of the following? (please check):

_____ Bleeding gums	_____ Swollen Gums	_____ Unpleasant taste
_____ Clenching or grinding	_____ Chronic Headache	_____ Pain around ear
_____ "Clicking" upon opening / closing	_____ Tooth Sensitivity	_____ Canker Sores
_____ Orthodontic Treatment	_____ Periodontal Treatment	_____ Chronic bad breath

Is there anything else you feel we should know? (please explain): _____

CERTIFICATION: I certify that the above answers are true and correct to the best of my knowledge.

Signature: _____ Date: _____