

Dockside Dental

1702 Highway 70 East, Suite E
New Bern, NC 28560

(252)638-3600



Chart #.
FOR OFFICE USE ONLY

Patient Name: Last First MI Preferred Name

Title: Mr/Ms/Mrs/etc Gender: Male Female Family Status: Married Single Child Other

Birth Date: SS #: Prev. Visit:

Email Address: Best time to call:

Phone: Home Work Ext Mobile Fax Other

Address:
 City State Zip Code

Employer Name:

Primary Dental Insurance

Secondary Insurance

Medical Information

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

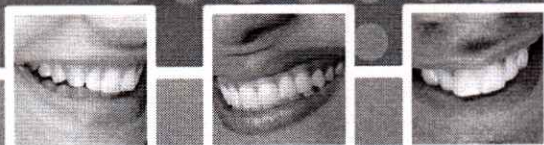
- | | | | |
|--|--|--|--|
| <input type="checkbox"/> *Pre-Med - Amox | <input type="checkbox"/> *Pre-Med - Clind | <input type="checkbox"/> *Pre-Med - Other | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Allergy - Aspirin | <input type="checkbox"/> Allergy - Codeine | <input type="checkbox"/> Allergy - Erythro | <input type="checkbox"/> Allergy - Hay Fever |

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|---|---|---|--|
| <input type="checkbox"/> Allergy - Latex | <input type="checkbox"/> Allergy - Other | <input type="checkbox"/> Allergy - Penicillin | <input type="checkbox"/> Allergy - Sulfa |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Medical Alert | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Other | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease | | |

PRE-MED patients: please list why Pre-Med is needed:

If there have been any medical changes since your last visit with us, please list below.

List all medications, drugs, pills or herbal remedies, including regular dosages of aspirin.

* By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

Signature: _____

Date:

Response Date: