Harborside Dental Associates, P.A.

522 E. Marion Avenue
Punta Gorda, FL 33950
941.575.9200
Daniel K. Moenning, D.D.S. & Michelle W. Moenning, D.D.S.

Patient Information

Date: _____

Patient Name: _____ My Friends Call Me: _____

Patient's Date of Birth: _____ Gender: □ Male □ Female

**Spouse's Name*: _____

If Child: *Mother's name*: _____ *Father's name*: _____

Home Address: _____
STREET CITY STATE ZIP

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Email Address: _____ **PREFERRED Contact Phone #:** _____

***Emergency Contact Name _____**
Relationship_____ Phone#: _____

Driver's License Number: _____ Social Security Number: _____

Whom may we thank for referring you to our office? □Yellow Pages □Website □ Insurance □ Other
Specify: _____

Employer: _____ Occupation: _____

Dental Insurance Information

****Harborside Dental does NOT verify *your* eligibility or *your* network status with *your* insurance company prior to appointments.**

It is your responsibility as the insured to know *your* benefits.

Name of Insured: _____ Relationship to Patient: □ Self □ Spouse □ Child □ Other
Insured's Date of Birth: _____ Insured's SS # or Member ID #: _____
Insured's Employer: _____
Insurance Company's Name: _____
Insurance Company's Address: _____
_____
Insurance Company's Phone: _____
Group or Policy #: _____

SECONDARY Insurance
Name of Insured: _____ Relationship to Patient: □ Self □ Spouse □ Child □ Other
Insured's Date of Birth: _____ Insured's SS # or Member ID #: _____
Insured's Employer:_____
Insurance Company's Name: _____
Insurance Company's Address: _____
_____
Insurance Company's Phone: _____
Group or Policy #: _____

Health Information

Date of Last Dental Visit: _____ Reason For This Visit: _____

Do you take pre-medication (antibiotics) before dental work? □ Yes □ No ***If yes: What do you take? _____

Have you ever had any of the following? Please check ALL that apply:

□ Codeine Allergy
□ Penicillin Allergy
□ Allergies _____
□ Environmental Allergies
□ ADHD – Meds: _____
□ Aids / HIV Positive
□ Alzheimer's / Dementia
□ Anemia
□ Aneurysm
□ Angina / Chest Pain
□ Arthritis
□ Artificial Joints: Date ____
□ Asthma
□ Blood Disease
□ Cancer –Type _____
Year _____
□ Chemotherapy
□ Cold Sores/Fever Blisters

□ Colitis / Gastro Issues
□ Congenital Heart Condition
□ COPD
□ Depression
□ Diabetes
□ Drug/Substance or Alcohol Abuse _____
□ Emphysema
□ Excessive Bleeding
□ Fainting / Dizzy Spells
□ Fibromyalgia
□ Frequent Headaches
□ Gerd
□ Glaucoma
□ Head Injuries
□ Heart Disease / Heart Attack
□ Heart Murmur
□ Heart Surgery _____

□ Hepatitis _____
□ High Blood Pressure
□ High Cholesterol
□ Kidney Disease
□ Liver Disease
□ Low Blood Pressure
□ Mental Disorders
□ Mitral Valve Prolapse
□ Multiple Sclerosis
□ Nervousness / Anxiety
□ Pacemaker / Year _____
□ Parkinson's Disease
□ Psychiatric Care /counseling
□ Radiation Treatment
□ Rheumatic Fever
□ Rheumatism
□ Seizures / Epilepsy
Last Episode: _____

□ Sinus Problems
□ Snoring
□ Stomach Problems / Ulcers
□ Stroke
□ TMJ Problems Clicking/Popping Jaw Joints
□ Tuberculosis
□ Tumors / Growths
□ Thyroid Problems
□ Venereal Disease
□ Other: _____
_____
_____
_____

□ Tobacco Use:
□ Cigarettes
□ Chewing Tobacco
How Often: _____

□ Osteoporosis – Meds: _____ How Long: _____
□ Blood Thinners: _____

Have you ever had complications with local anesthetic? □ Yes □ No

Have you had any complications or unpleasant experiences with any dental treatment? □ Yes □ No
If yes, please explain: _____

Have you ever had any type of surgery: □ Yes □ No Were there any complications? □ Yes □ No

Have you been admitted to a hospital or needed emergency care within the last two years? □ Yes □ No
If yes, please explain: _____

Are you under the care of a physician? □ Yes □ No
If yes, please explain: _____

Name of Physician: _____ Phone Number: _____

Are you currently taking any prescription or over the counter medication? □ Yes □ No
***List all medications, prescription and over the counter** (including vitamins): _____
_____

_____

***Women** – Are you pregnant: _____ If yes / what month: _____

****** *To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I understand that it is my responsibility to inform the doctors at Harborside Dental Associates of any such changes prior to treatment.*

_____ _____ Date: _____
Print Patient Name Signature of patient, parent or guardian

HARBORSIDE DENTAL ASSOCIATES
NOTICE OF PRIVACY PRACTICES
Effective Date: February 16, 2026

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

OUR RESPONSIBILITIES
Harborside Dental Associates is required by law to protect the privacy and security of your protected health information (PHI), provide you with this Notice of Privacy Practices, and follow the terms of this Notice.

HOW WE USE AND SHARE YOUR INFORMATION
Treatment: We may use and share your health information to provide and coordinate your dental care.
Payment: We may use and share your information to bill insurance plans or other responsible parties.
Healthcare Operations: We may use and share your information for office operations such as quality improvement, training, and administrative activities.

SPECIAL PROTECTIONS FOR SUBSTANCE USE DISORDER (SUD) RECORDS
If we create or receive substance use disorder records protected under 42 CFR Part 2, those records receive additional legal protections. These records generally cannot be used or disclosed in legal proceedings against you without your written consent or a qualifying court order.

OTHER PERMITTED DISCLOSURES
We may disclose information as required by federal or Florida law, for public health and safety purposes, or for fundraising communications (you may opt out at any time). Substance use disorder information will not be used for fundraising without authorization.

REDISCLOSURE NOTICE
Information disclosed under this Notice may be redisclosed by the recipient and may no longer be protected by HIPAA, unless prohibited by law.

YOUR RIGHTS
You have the right to access your records, request corrections, request confidential communications, request limits on certain disclosures, receive a list of certain disclosures, obtain a copy of this Notice at any time, and file a complaint without retaliation.

QUESTIONS OR COMPLAINTS
Privacy Officer
Harborside Dental Associates
522 E. Marion Ave
Punta Gorda, FL 33950
Phone: 941-575-9200

You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

ACKNOWLEDGMENT OF RECEIPT
I acknowledge that I have received a copy of the Notice of Privacy Practices for Harborside Dental Associates.

Patient Name: _____

Signature: _____ Date: _____

Harborside Dental Associates

Daniel K. Moenning D.D.S.
Michelle W. Moenning D.D.S.

~ Broken Appointment Policy ~

Harborside Dental is dedicated to providing quality dental care to all of our patients. We do our best to ***respect*** our patient's time and make every effort to remain on schedule. Some dental visits can become more complicated than initially anticipated, and emergencies may arise that could possibly delay us. In such a case, every effort will be made to notify you beforehand.

Because we reserve time exclusively for each patient, we ask that you make every effort to keep your reserved dental appointment. If you find that you cannot keep your originally scheduled appointment, we require a minimum 24 hour notification. This will allow your reserved time to be offered to other patients in need of treatment. We ask that you call our office during ***business hours*** to notify us of any changes that need to be made.

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Every effort will be made to contact our patients to confirm appointments. Please understand that this is a courtesy call, text, or email which is contingent on the information you have provided our office. We *do* understand that there can be unforeseen circumstances and/or emergencies that may cause reserved appointments to be missed without 24 hours' notice.

Our new "**Broken Appointment**" & "**No Show**" Fee Policy is as follows:

- If you fail to give our office 24 hour notice of cancellation, or no show for a reserved appointment, Harborside Dental Associates reserves the right to charge a broken appointment fee of $75.00.

- All broken appointment fees will be billed to the patient and must be paid prior to your next appointment. In order to schedule future appointments, prepayment will be required.

- If you have multiple broken appointments in any 12 month period, it may result in dismissal from our practice.

We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, please ask.

_____ I have read and understand the broken appointment policy at Harborside Dental
Initial

_____
Print Name

Health History Update

Patient Name: _____ Date of Birth: _____

Home Address: _____ Preferred Contact Phone #: _____

_____ Email: _____

Emergency Contact: _____ Phone #: _____

Dental Insurance: _____

Has your INSURANCE changed? □ Yes □ No

Do you take pre-medication (antibiotics) before dental work? □ Yes □ No *If yes: What do you take? _____

Have you ever had any of the following? Please check ALL that apply:

□ Codeine Allergy
□ Penicillin Allergy
□ Allergies _____
□ Environmental Allergies
□ ADHD – Meds: _____
□ Aids / HIV Positive
□ Alzheimer's / Dementia
□ Anemia
□ Aneurysm
□ Angina / Chest Pain
□ Arthritis
□ Artificial Joints: Date ____
□ Asthma
□ Blood Disease
□ Cancer –Type _____
Year _____
□ Chemotherapy
□ Cold Sores/Fever Blisters

□ Colitis / Gastro Issues
□ Congenital Heart Condition
□ COPD
□ Depression
□ Diabetes
□ Drug/Substance or Alcohol Abuse _____
□ Emphysema
□ Excessive Bleeding
□ Fainting / Dizzy Spells
□ Fibromyalgia
□ Frequent Headaches
□ GERD
□ Glaucoma
□ Head Injuries
□ Heart Disease / Heart Attack
□ Heart Murmur
□ Heart Surgery _____

□ Hepatitis _____
□ High Blood Pressure
□ High Cholesterol
□ Kidney Disease
□ Liver Disease
□ Low Blood Pressure
□ Mental Disorders
□ Mitral Valve Prolapse
□ Multiple Sclerosis
□ Nervousness / Anxiety
□ Pacemaker / Year _____
□ Parkinson's Disease
□ Psychiatric Care /counseling
□ Radiation Treatment
□ Rheumatic Fever
□ Rheumatism
□ Seizures / Epilepsy

□ Sinus Problems
□ Snoring
□ Stomach Problems / Ulcers
□ Stroke
□ TMJ Problems Clicking/Popping Jaw Joints
□ Tuberculosis
□ Tumors / Growths
□ Thyroid Problems
□ Venereal Disease
□ Other: _____
_____
_____
_____
□ Tobacco Use:
□ Cigarettes
□ Chewing Tobacco

Last Episode: _____ How Often: _____

□ Osteoporosis – Meds: _____ How Long: _____

□ Blood Thinners: _____

Are you currently taking any prescription or over the counter medication? □ Yes □ No

***List all medications, prescription and over the counter** (including vitamins): _____

_____

_____

* Have you ever had any type of surgery: □ Yes □ No Were there any complications? □ Yes □ No

* Have you been admitted to a hospital or needed emergency care within the last two years? □ Yes □ No

If yes, please explain: _____

♦ **Women** – Are you pregnant: _____ If yes / what month: _____ / Due Date: _____

♦♦♦ ***To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I understand that it is my responsibility to inform the doctors at Harborside Dental Associates of any such changes prior to treatment.***

_____ _____ Date: _____

Print Patient Name Signature of patient, parent or guardian