

Harborside Dental Associates, P.A.

522 E. Marion Avenue
Punta Gorda, FL 33950
941.575.9200

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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:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Colitis / Gastro Issues | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Congenital Heart Condition | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> COPD | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stomach Problems / Ulcers |
| <input type="checkbox"/> Environmental Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> ADHD – Meds: _____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> TMJ Problems |
| <input type="checkbox"/> Aids / HIV Positive | <input type="checkbox"/> Drug/Substance or | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Clicking/Popping Jaw Joints |
| <input type="checkbox"/> Alzheimer's / Dementia | Alcohol Abuse _____ | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tumors / Growths |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Angina / Chest Pain | <input type="checkbox"/> Fainting / Dizzy Spells | <input type="checkbox"/> Nervousness / Anxiety | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Pacemaker / Year _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Artificial Joints: Date _____ | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Parkinson's Disease | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gerd | <input type="checkbox"/> Psychiatric Care /counseling | _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation Treatment | _____ |
| <input type="checkbox"/> Cancer –Type _____ | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tobacco Use: |
| Year _____ | <input type="checkbox"/> Heart Disease / Heart Attack | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Cigarettes |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Seizures / Epilepsy | <input type="checkbox"/> Chewing Tobacco |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Surgery _____ | Last Episode: _____ | How Often: _____ |
| <input type="checkbox"/> Osteoporosis – Meds: _____ | | How Long: _____ | |
| <input type="checkbox"/> 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.**

Print Patient Name

Signature of patient, parent or guardian

Date: _____