

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:

<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	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"/> _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gerd	<input type="checkbox"/> Psychiatric Care /counseling	<input type="checkbox"/> _____
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> _____
<input type="checkbox"/> Cancer –Type _____ Year _____	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Tobacco Use:
	<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.