



A Private Practice for Children & Adults
901 Schneider St. SE, North Canton, Ohio 44720
330-494-6016
www.DannerDental.com

PATIENT INFORMATION

(Circle one) Mr. Mrs. Ms. Miss Dr. _____
(First Name) (Prefers to be Called) (Last Name)
Address: _____
(Street Address) (City) (State) (Zipcode)

(Home Phone) (Work Phone) (Cell Phone)
E-mail: _____ Marital Status: Single Married Divorced Widowed

Whom may we thank for referring you? _____
Date of Birth: _____ Sex: M F Social Security #: _____ - _____ - _____
Employer: _____ Occupation: _____
Employer's address: _____
(Street Address) (City) (State) (Zipcode)
Notify in case of emergency: _____ Relationship: _____
Emergency Contact's phone: _____ Cell phone: _____

PRIMARY DENTAL INSURANCE

Subscriber name: _____ Relation to patient: _____
Subscriber's social security #: _____ - _____ - _____ Subscriber's date of birth: _____
Address (if different from patient): _____
(Street Address) (City) (State) (Zipcode)
Subscriber's employer: _____ Employer's Phone: _____
Employer's address: _____
(Street Address) (City) (State) (Zipcode)
Plan Name: _____ Group #: _____
Insurance Company: _____ Insurance Phone: _____
Insurance Address: _____
(Street Address) (City) (State) (Zipcode)

SECONDARY DENTAL INSURANCE

Subscriber name: _____ Relation to patient: _____
Subscriber's social security #: _____ - _____ - _____ Subscriber's date of birth: _____
Address (if different from patient): _____
(Street Address) (City) (State) (Zipcode)
Subscriber's employer: _____ Employer's Phone: _____
Employer's address: _____
(Street Address) (City) (State) (Zipcode)
Plan Name: _____ Group #: _____
Insurance Company: _____ Insurance Phone: _____
Insurance Address: _____
(Street Address) (City) (State) (Zipcode)

MEDICAL HISTORY

Physician's name: _____ Phone: _____

Physician's address: _____
(Street Address) (City) (State) (Zipcode)

Please circle any of the following to which you are allergic: Latex Codeine Dental anesthetics

Are you allergic to any antibiotics? YES NO If yes, please list: _____

Please list any other allergies you have: _____

Do you need to pre-medicate prior to dental appointments? YES NO If yes, please explain: _____

List all other medications you are currently taking, and include the reason(s) why: _____

Are you diabetic? YES NO Do you have high blood pressure? YES NO

Please list any heart problems you currently have or have had in the past: _____

Do you have any artificial joints? YES NO If yes, please list: _____

Please list all other diseases or medical issues you currently have or have had in the past: _____

Do you currently have a chemical dependency? YES NO Tobacco habit? YES NO

(For Women) Are you pregnant or possibly pregnant? YES NO Are you nursing? YES NO

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ Date: _____

Payment is due in full at the time of treatment, unless prior arrangements have been approved. Thank you.