DR.DONALD T. NORBY DMD
PEDIATRIC DENTISTRY
TP: 256-238-9233 FAX: 256-237-8472

CHILD'S FULL NAME_____ Name child goes by_____

Mailing Address_____ City_____ State_____ Zip_____

Home Phone _____ Date of Birth _____ Age _____ Sex MALE FEMALE

School Child Attends_____ Grade _____

FATHER / GUARDIAN'S FULL NAME _____

Mailing Address_____ City_____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security #_____ Date of Birth _____ Driver's License #_____

Employer _____

E-Mail_____

MOTHER / GUARDIAN'S FULL NAME _____

Mailing Address_____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Date of Birth _____ Driver's License #_____

Employer_____

E-Mail_____

DENTAL INSURANCE INFORMATION
PRIMARY INSURANCE

Name of Card Holder_____ Contract #_____ Group #_____

Employer _____Card Holder's Social Security #_____ Date of Birth _____

Name of Insurance Co. _____ Phone #_____

SECONDARY INSURANCE

Name of Card Holder_____ Contract #_____ Group #_____

Employer _____Card Holder's Social Security #_____ Date of Birth _____

Name of Insurance Co. _____ Phone #_____

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Fees are to be paid at the time of treatment. If you have insurance we are happy to file insurance for you, but all deductibles and percentages not covered by your insurance are due at the time of treatment. You are responsible for all charges incurred that your insurance company does not pay. We are unable to carry accounts longer than 30 days. If your insurance has not paid on your account within 30 days of the service date, then, your account will be due in full. It is your responsibility to call your insurance company and insure that the account is paid. It is important that you supply our office with all insurance information requested above. If we are asked to re-file for you due to incorrect information received at the time of service, then a $5.00 service charge will be added to your account. In the event of non-payment of charges for dental services rendered, I agree to pay all costs of collections including a reasonable attorney's fee, court cost, and a service charge of 1.5% of my unpaid balance after ninety days. I hereby waive all rights of exemption under the Constitution on the State of Alabama. I have read, or have had read to me, this contract and understand its provisions.

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Signature_____ Relationship_____Date_____

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NAME:_____ DATE OF BIRTH:_____

Has this child ever had any treatment for any of the following? **Please check Yes or No.**

Yes	No		Yes	No		Yes	No	
□	□	Blood – Circulatory	□	□	Gastrointestinal – Stomach	□	□	Muscles
□	□	Bones	□	□	Kidney – Bladder	□	□	Nervous System
□	□	Endocrine Glands	□	□	Heart	□	□	Skin
□	□	Eyes-Ears-Nose-Throat	□	□	Liver	□	□	Tonsils-Adenoids
□	□	Respiratory						

Has this child ever been diagnosed as having any of the following conditions? **Please check Yes or No.**

Yes	No		Yes	No		Yes	No	
□	□	ADHD	□	□	Eye Problems_____	□	□	Rheumatic Fever
□	□	AIDS	□	□	Excessive Bleeding Problem	□	□	Scarlet Fever
□	□	Anemia	□	□	Hearing Loss	□	□	Sickle Cell Anemia
□	□	Allergies…Please List:	□	□	Heart Disease	□	□	Sinus Problems
		_____	□	□	Heart Murmur… Is Pre-medication needed? _____	□	□	Snoring at Night?
		_____				□	□	Sore Throat
□	□	Arthritis	□	□	Hemophilia	□	□	Spina Bifida
□	□	Asthma	□	□	Hepatitis-Type_____	□	□	_____Syndrome
□	□	Autism	□	□	Jaundice	□	□	Tuberculosis
□	□	Brain Injury	□	□	Leukemia	□	□	Cancer/Chemo/ Radiation Treatment
□	□	Cancer	□	□	Intellectual Disability			
□	□	Cerebral Palsy	□	□	Mouth Breathing			Specify If Yes:_____
□	□	Cleft Lip-Palate	□	□	Orthopedic Problems			_____
□	□	Convulsions-Seizures	□	□	Pregnant			_____
□	□	Diabetes	□	□	Psychiatric Disorder			
□	□	Drug/Alcohol Abuse						
□	□	Epilepsy						

Previous Dentist_____ Date of last check up & cleaning_____

Previous Dentist concerns_____

Medications Currently Taking_____

Primary Physician_____

Is there anything else we should know about your child? _____
_____
_____
_____

I certify that I have read and understand the above questions. I will not hold Dr. Norby or any member of his staff responsible for any errors or omissions I may have made in the completion of this form.

Signature_____ Relationship_____ Date_____