F. KENT NORRIS D.M.D.
FAMILY DENTISTRY

PATIENT INFORMATION

DR.
MR.
MRS
MISS _____(_____)_____ **HOME PHONE** (_____)_____--_____
(FIRST) (MIDDLE) (PREFERRED) (LAST)

PATIENTS CELL (_____)_____--_____

ADDRESS_____CITY_____STATE_____ ZIP_____
(P. O. BOX **AND** STREET ADDRESS)

E-MAIL ADDRESS _____ (This may be used to contact you concerning your appointment.)

SOCIAL SECURITY NUMBER _____--_____--_____ DATE OF BIRTH _____/____/_____ AGE _____ SEX _____

EMPLOYER _____ EMPLOYERS ADDRESS_____ CITY_____ STATE_____

__ SINGLE __ MARRIED__ CHILD __ DIVORCED __ WIDOWED **WORK PHONE** (_____)_____ --_____

EXTENSION / DEPT _____

SPOUSE / MOTHER / GUARDIAN (IF UNDER 18)

NAME _____ RELATIONSHIP TO PATIENT_____ **HOME PHONE** (_____) _____--_____
(FIRST) (MIDDLE) (LAST)

ADDRESS_____ CITY _____STATE_____ ZIP_____ **CELL** (_____) _____--_____
(P. O. BOX **AND** STREET ADDRESS)

SOCIAL SECURITY NUMBER _____--_____-- _____ DATE OF BIRTH _____/ _____/ _____ AGE _____ SEX_____

EMPLOYER _____ EMPLOYERS ADDRESS _____ CITY _____ STATE_____

WORK PHONE (_____) _____--_____ **EXTENSION / DEPT.**_____

FATHER / GUARDIAN (IF UNDER 18)

NAME _____RELATIONSHIP TO PATIENT _____**HOME PHONE** (_____) _____--_____
(FIRST) (MIDDLE) (LAST)

ADDRESS_____ CITY _____STATE_____ZIP_____ **CELL** (_____) _____--_____
(P. O. BOX **AND** STREET ADDRESS)

SOCIAL SECURITY NUMBER _____--_____--_____ DATE OF BIRTH _____/_____/_____ AGE _____ SEX _____

EMPLOYER _____ EMPLOYERS ADDRESS _____ CITY _____ STATE_____

WORK PHONE (_____) _____--_____

How did you hear about out office? _____.

EXTENSION / DEPT _____

DENTAL INSURANCE INFORMATION

PRIMARY **NAME OF INSURANCE** __ __ **POLICY NUMBER** _____--_____--_____

NAME OF INSURED _____ **GROUP NUMBER** _____

SECONDARY

NAME OF INSURANCE _____ **POLICY NUMBER** _____--_____--_____

NAME OF INSURED _____ **GROUP NUMBER** _____

Please Circle If you Have Any of the Following:

Heart Disease, High Blood Pressure, Kidney Disease, Diabetes, Liver Disease, AIDS / HIV, Asthma, Artificial Joints
Heart Murmur, Radiation Therapy, Tuberculosis, Cancer, Emphysema, Anemia (_____ what joint?)
Heart Attack, Rheumatic Fever, Bleeding Problems, Seizures, Glaucoma, Hepatitis (_A –B -C_ which one?)
Mitral Valve Prolapse (MVP), Pacemaker, Artificial Heart Valve, Stints _____ When?_____
Other ?_____

- Are you under the care of a physician at the present? Y / N _____.
- Name and phone number of physician. _____Phone:(_____)_____--_____.
- Are you allergic to any foods, drugs or other? _____Y / N_____. If so list _____.
- Have you had any complications from taking local anesthesia? Y / N If so explain _____.
- **Female are you pregnant? If so how far along are you?** _____.
- Are you currently taking any medications or have you recently stopped taking any medications? _Y / N__ If so list _____.

I understand that I am responsible for any and all unpaid balance that my insurance, if any, does not cover. I understand that there is no guarantee of the coverage or co-pay information given to me by this office. I understand it is my responsibility to notify the office of any changes in my coverage, health and all personal information. I also give my permission for treatment for myself and / or my child. ALL CO-PAYS ARE DUE THE DAY SERVICES ARE PERFORMED

_____ **Date** _____/_____/_____.
(Signature of Patient, Parent or Guardian)

(Please provide your dental insurance card, driver's license and a list of any medications you are currently taking.)