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 #____________________

****

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.

****

Signature____________________ Relationship____________________Date______________