Date: ______________________________

No: ______________________________

PLEASE PRINT IN INK

Don F. Norris, D.M.D., M.S.
701 Montgomery Hwy., Suite 201
Vestavia Hills, AL 35216
p. (205) 978-1500
f. (205) 978-8855
www.norrisortho.com

MEDICAL HISTORY

please check if patient has or has had the following:

- [ ] joint swelling
- [ ] bone disorders
- [ ] heart trouble
- [ ] mitral valve prolapse
- [ ] rheumatic trouble
- [ ] diabetes
- [ ] emotional problems
- [ ] brain injury
- [ ] kidney or liver involvement
- [ ] joint prosthesis
- [ ] tuberculosis
- [ ] anemia
- [ ] epilepsy (convulsions)
- [ ] prolonged bleeding
- [ ] faintness/dizziness
- [ ] tonsils removed
- [ ] adenoids removed
- [ ] sore throat
- [ ] tonsillitis
- [ ] earaches
- [ ] arthritis
- [ ] latex allergy
- [ ] thyroid problems

have you or any members of your family had:

[Y] [N] rheumatoid arthritis?

[Y] [N] lupus?

on items checked, please provide a more detailed description:

____

____

____

is patient presently under physician care for any reason?

____

name of primary physician ______________________________

other ______________________________

list any other serious illnesses

____

adolescent females: has menstruation begun?

date month/year ______________

approx. how much has the patient grown in the last year? ______

DENTAL HISTORY

please check if patient has or has had the following:

- [ ] any injuries to face, mouth, or teeth
- [ ] thumb, finger, or lip sucking
- [ ] more than average amount of tooth decay
- [ ] extra permanent teeth
- [ ] teeth removed by extraction
- [ ] difficulty in swallowing or chewing
- [ ] any pain or clicking when opening mouth
- [ ] is the patient adopted? at what age? ______
- [ ] previously consulted by another orthodontist

[Y] [N] does the patient visit the dentist regularly?

date of last visit ______________

on items checked, please provide a more detailed description:

____

____

list drugs or medications now being taken

____

____

____

do you take any medications for osteoporosis? [Y] [N]

if yes, please list: ______________________________

list any allergies

____

what do you want to accomplish with orthodontic treatment?

____

patient's attitude toward orthodontic treatment:

very motivated | will cooperate if needed | not motivated

Signature ______________________________ Date ______________

Date: ______________________

No: ______________________

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PATIENT INFORMATION

last name	first name	nickname	ssn	sex	birth date	age

mailing address	city	state	zip	home #

school (if student)	grade	[ ]single [ ]married	[ ] divorced [ ] widow	employer/occupation	work #

email	fax #	cell #

who may we thank for recommending us?	name of dentist	date of last visit

related patients that are or have been under our care	names and ages of other children
1.	1.
2.	2.
3.	3.
4.	4.

PARENT INFORMATION (please complete if patient is a minor)

father's name	ssn
address	
city	state / zip
email	
home #	cell #
employer/occupation	work #

mother's's name	ssn
address	
city	state / zip
email	
home #	cell #
employer/occupation	work #

INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT

name	relation to patient	employer/occupation

mailing address	city	state	zip	home #

work #	cell #	fax #	email

insurance company	contract number	group number	group member birth date

if divorce is involved, who is the custodial parent?	may patient information be released to the non-custodial parent? [ ] yes [ ] no