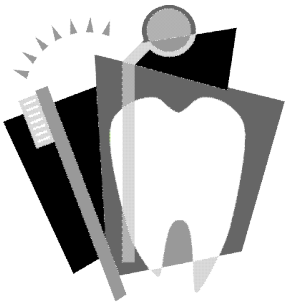
Sonja G. Norris, DDS
General Dentistry



Patient Registration

Date_____

Is English spoken fluently in your home? ☐ Yes ☐ No

If no, what is the primary language spoken in your home? _____

Patient's Full Name _____

Patient prefers to be called _____

SS#, MI Child #, etc. _____

Patient's Date of Birth _____ Age _____

Name of person(s) with whom patient resides: ☐ Parent ☐ Guardian

_____ _____

Street Address _____

City_____ Zip Code _____ Phone_____

Foster Parents you are required to provide a document from your caseworker stating that you are authorized to seek dental/medical care for this child in your care. Legal Guardians, you are required to provide documents from the court that indicate you are the legal guardian of this child. Documents must be presented with this paperwork at the child's appointment or the appointment will need to be rescheduled. A parent, foster parent, or legal guardian must accompany the child to their first dental appointment to our office.

Father's Name _____

Address (if different than above) _____

_____

Home Ph _____ Work Ph_____ Cell _____

Date of Birth _____ Marital Status _____

Employer _____ Occupation_____

Dental Insurance Carrier _____

SS# _____ Group #_____

Mother's Name _____

Address (if different than above) _____

_____

Home Ph _____ Work Ph_____ Cell _____

Date of Birth _____ Marital Status _____

Employer _____ Occupation_____

Dental Insurance Carrier _____

SS# _____ Group #_____

Most of our new patients are by referral. All referrals are a compliment to our practice and as such, we'd like to thank the person who referred you to our practice. Whom may we thank for referring you?

Mr. ☐ Mrs. ☐ Miss. ☐ Ms. ☐ Dr. ☐

_____

_____

_____

1040 Charlevoix Drive • Suite A • Grand Ledge, MI 48837 • Office (517) 622-4014 • Fax (517) 622-4018

Payment Policy

The person who accompanies the patient to the dental office and/or signs the consent is responsible for the account. Payments/Co-payments are collected upon check-in on the day of treatment.

We will not split billings for situations of separations or divorce. Payment arrangements must be resolved between parental parties before treatment begins.

In order to keep our fees down, we prefer not to bill. We expect payment on the date services are rendered. We will bill only any differences between our estimates and actual insurance payments (requiring a higher co-pay), or in cases where more treatment was required than anticipated. In these cases, payment is due within 10 days after receipt of our bill.

We accept payment by cash, check, Visa, MasterCard, or Discover. There is an NSF charge for returned checks. Ask our receptionist about the CareCredit interest free payment plans for dental services. As well, we also offer a 5% accounting courtesy for all treatment over $500 that is paid in full prior to treatment commencing. This is payable by cash or money order only.

If you are covered by an accepted dental insurance plan:

We, as your dental provider, will prepare your insurance claim form and forward it to your insurance carrier on your behalf. As the parent/guardian, you are responsible for the total fee and are expected to make up for any deficiencies in the insurance coverage, according to plan specifications.

For services rendered in the hospital, we will obtain preauthorization from your insurance carrier prior to treatment (for anesthesia and hospitalization). However, you as the parent/guardian, are responsible for any deficiencies in coverage as well as co-payments. We suggest that you speak with your insurance representative, prior to treatment, for details regarding your plan coverage.

Consent for Treatment

I hereby authorize dental treatment for_____. This authorization includes procedures which are reasonable and customary for children's dentistry and deemed necessary by Dr. Norris and/or her dental associates. Comprehensive exams are customary prior to any treatment. Treatment plans may change from doctor to doctor and may change based on the length of time from the point of diagnosis to date of treatment. Any significant changes will be discussed with the parent prior to rendering treatment.
I also agree to pay the fees that are established by the payment policy above for all treatment rendered.

Signature _____ Date _____

Reserved Appointments

When an appointment is reserved for your child, the time of the doctor, the support staff, and the operatory is reserved for your child alone. Missed appointments are costly to everyone and prevent us from seeing others in need. Therefore, we request 24 hours notice if you are unable to be here. Appointments cancelled with less than 24 hours notice are subject to a $60 rescheduling charge. No charge will be made for a missed appointment if this request is honored. The office telephone is answered 24/7 should you need to leave a message at night or on weekends. Patients who arrive 15 minutes late for appointments will not be seen that day, but instead, will be rescheduled for a future date with a $30 rescheduling fee. No-shows and short-notice cancellations are cause for release from the practice.

Our office reserves the right to release patients from the practice for abuses to the appointment policy.