NORMAN C. GUILLEN, D.M.D., PC

Dentistry

Welcome to our practice!

Date: _____

PATIENT INFORMATION

Name: _____ Birthdate: _____ Sex ❑ F ❑ M
Last First Middle Mo Day Year

Address _____
Street Apt # City State Zip

Soc Sec # _____ Married ❑ Single ❑ Minor ❑ Phones _____ _____ _____
Home Work Cell

Occupation: _____ Employer (or School) _____

Business Address: _____
Street City State Zip

E-Mail Address: _____

Whom may we thank for referring you to our office? _____

Has any member of your family ever been treated in our office? _____

What name do you prefer to be called? _____ Name of Spouse? _____

Name to contact in Case of Emergency _____ Phone # _____

ACCOUNT INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____ Birthdate: _____ Relationship: _____
Last First M Mo Day Year

Address _____
Street Apt # City State Zip

Soc Sec # _____ Driver's License # _____

Phones: _____ _____ _____
Home Work Cell

Occupation: _____ Employer: _____

Business Address: _____
Street City State Zip

DENTAL INSURANCE INFORMATION

Insured's Date of Birth _____

Insurance Company: _____ Group No. _____ Insured's SS# _____

Policy Holder: _____ Employer: _____ Phone: _____

Employer's Address: _____
Street City State Zip

Are you covered under more than one dental plan? ❑ YES ❑ NO
If yes, please fill out next section.

Insured's Date of Birth _____

Insurance Company: _____ Group No. _____ Insured's SS# _____

Policy Holder: _____ Employer: _____ Phone: _____

Employer's Address: _____
Street City State Zip

About Your Account...

We will make every effort to make your dental needs financially comfortable for you. In general, payment is required at the time of the service unless other arrangements are made in advance. A re-billing fee of 1 -1/2% per month (18% per annum) will be charged on the unpaid balance on all accounts exceeding sixty (60) days unless previous written financial arrangements are satisfied. All collection charges and reasonable attorney's fees incurred to effect collection on this account shall be paid by the patient.

Signature: _____