BRILLIANCE DENTAL CLINIC

Personal Information Form

Date: _____

Name: _____ Date of Birth: _____

Title: _____ Gender: ☐ Male ☐ Female

Address: _____ Home Phone: _____

City: _____ Province: _____ Work Phone: _____

Postal Code: _____ Cell Phone: _____

Email: _____

Most convenient way to contact you? ☐ Email ☐ Work Phone ☐ Cell Phone ☐ Home Phone

Employer: _____ Marital Status: _____ Name of spouse: _____

Emergency Contact: _____ Phone: _____

(If Child) Name of parent or guardian: _____

Family Medical Doctor: _____ Address: _____

Phone: _____

Previous Dentist: _____ Do you have dental insurance: ☐ YES ☐ No

If Yes please provide the following:

Insurance Information

Primary Insurance Co: _____ Policy: _____

ID: _____

Policy Holder: _____ Date of Birth: _____

Relationship to Client: _____ Employer: _____

If you have more than one insurance policy complete this section:

Secondary Insurance Information

Secondary Insurance Co: _____ Policy: _____

ID: _____

Policy Holder: _____ Date of Birth: _____

Relationship to Client: _____ Employer: _____

Dental Benefit plans are not accepted as payment, all fees must be paid directly to Brilliance Dental Clinic. Claim forms will be completed by Brilliance Dental for the patient to seek reimbursement from their insurer.