Date_____

Name_____ Date of Birth_____ Gender: M F Other: _____
Last First Name Initial Month Day Year

Address_____
Street City Postal Code

Res Phone_____ Bus Phone_____ Cell_____

E-Mail_____ **What is the most convenient way to contact you? _____**

Employer_____ Marital Status_____ Name of spouse_____

Emergency Contact_____ Phone_____

(If Child) Name of parent or guardian_____

Family Medical Doctor_____
Name Address Phone Number

Previous Dentist _____ Do you have dental insurance Yes No

If Yes please provide the following:

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 Co_____Policy_____ID_____

Policy Holder_____ Date of Birth_____Relationship to Client_____

Employer_____

Please be aware that Brilliance Dental DOES NOT direct bill to your insurance company for payment .The patient is responsible to pay the day of the visit and we will submit the claim to the insurance company on your behalf.
Thank-you