UNDER 18

Patient Information Form

Randall J Russell, DDS

6240 S. Main Street Suite 255 Aurora, CO 80016 **720-870-1451**

Patient Name	Date of Birth	Age	Today's Date
Address	City/State	Zip	Home Phone #
Cell Phone #	Parent/Guardian Name		Social Security No.
Employer	Email Address		
Emergency Contact	Relationship		Phone
Pharmacy AND CROSS STREETS	Person responsible for bill:		
Whom may we thank for referring you to us?			

Insurance Information

Primary Insurance Name	Phone	Address	
Name of Insured/DOB	Relationship	Social Security# + ID#	Group No.
Employed By		Business Phone	
Secondary Insurance Name	Phone	Address	
Name of Insured/DOB	Relationship	Social Security# + ID#	Group No.
Employed By		Business Phone	

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr. Randall J Russell all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially res for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I certify that all information above is correct and true to my knowledge.

Responsible Party Signature Relationship Date

For Office Use Only

Deductible	Met	Effective Date	Contact Person
O.S. Benefits %	Yearly Max	Used	IV Sedation %