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	Marital Status	Today's Date

Address	City/State	Zip	Home Phone	Cell Phone

Employer Name	Occupation	Social Security No.

Email Address:	Spouse Name	DOB	Social Security No.

Emergency Contact	Relationship	Phone

Preferred Pharmacy/	Pharmacy phone number or cross streets?

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 responsible 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 %