

# 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	
<b>Pharmacy AND CROSS STREETS</b>	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 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
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### For Office Use Only

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