

RUSSELL FAMILY & COSMETIC DENTISTRY

Patient Name _____ Date _____
First MI Last Preferred Name

Address _____
Street City State Zip

Gender (M/F) _____ Marital Status _____ Birth Date _____ Social Security # _____ Driver's License# _____

Phone #s: Home _____ Work _____ Cell _____ Other _____ Best time to call _____

E-mail Address _____ Employer _____ How long _____ Occupation _____

Employer's Address _____
Street City State Zip

Spouse or Parent Information:

Name _____ Relationship _____ Date of Birth _____ Home Phone _____ Work _____

Cell _____ Driver's License# _____ E-mail Address _____ Social Security# _____

Address _____
Street City State Zip

Employer _____ How long _____ Occupation _____

Employer's Address _____
Street City State Zip

Primary Insurance	Dental	Medical
Insurance Co		
Insurance Phone #		
Subscriber's Name		
Relationship to Subscriber		
Subscriber's SS# / ID#		
Group #		
Subscriber's Date of Birth		
Subscriber's Employer		

Secondary Insurance	Dental	Medical
Insurance Co		
Insurance Phone #		
Subscriber's Name		
Relationship to Subscriber		
Subscriber's SS# / ID#		
Group #		
Subscriber's Date of Birth		
Subscriber's Employer		

Nearest Friend/Relative not living with you _____ Phone: _____ Address: _____

How did you hear about our office? _____

Assignment of Benefits and release of Information:

I authorize my insurance benefits to be paid directly to the dentist. I authorize Dr Russell to release any medical/dental information requested to secure the payment of benefits. I am financially responsible for any balance due for myself /dependent, due and payable at the time services are rendered unless other arrangements have been made. I understand if the account becomes more than 60 days past due, interest charges will be assessed.

Signature _____ Date _____