Patient Information: Eric Russell, D.D.S 5685 S. 1475 E., Suite 4A So. Ogden, Utah 84403

Patient Name _____Birthdate_____
Address_____City_____State_____Zip_____
Cell Phone_____ Home Phone_____
Patient Social Security #_____-_____-_____
Email_____
Spouse's Name (if married)_____ or Parent's Name (if minor)_____
Whom may we thank for referring you?_____

RESPONSIBLE PARTY: (____check if same as above)

Name of person responsible for the account_____ Relationship_____
Address_____City_____State_____Zip_____
Cell Phone_____ Home Phone_____
Social Security #_____-_____-_____
Email_____

- Is this person currently a patient in our office? _____yes _____no

PRIMARY INSURANCE: (we require a current copy of your insurance card)

Name of insured_____Relationship_____
Birthdate_____ SSN#_____-_____-_____Cell
Phone_____
Name of Employer_____ Work Phone_____
Insurance Company_____ Group#_____
ID#_____
Insurance Co.
Address_____City_____
State_____ Zip_____ Phone_____

SECONDARY INSURANCE: (we require a current copy of your insurance card)

Name of insured_____Relationship_____
Birthdate_____ SSN#_____-_____-_____Cell
Phone_____
Name of Employer_____ Work Phone_____
Insurance Company_____ Group#_____
ID#_____
Insurance Co.
Address_____City_____
State_____ Zip_____ Phone_____

Authorization and Release: I certify that I have read and understand the above information to the best of my knowledge. I have answered the above questions accurately. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers. I hereby give my consent to perform any treatment necessary for my dental health.

Signature:_____Date:_____
(Patient, parent, or legal guardian)