

Russell Orthodontics

RELEASE AND ASSIGNMENT

PRIMARY INSURANCE

Patients: Name: _____

Primary Insured Name: _____

Employer: _____

Insured's S.S. #: _____

Insured's Date of Birth: _____

Dental Ins. Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group #: _____

Effective Date: _____

SECONDARY INSURANCE

Insured Name: _____

Employer: _____

Insured's S.S. #: _____

Insured's Date of Birth: _____

Dental Ins. Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group #: _____

Effective Date: _____

I hereby authorize the release of any information including diagnosis of treatment or examinations rendered, to my insurance company or companies. I hereby authorize payment to the above name dentist of the insurance benefits otherwise payable to me.

*Failure to fully complete Release and Assignment could result in delay or nonpayment of claims.

SIGNED: _____

(Primary Insured)

SIGNED: _____

(Secondary Insured)

DATE: _____

DATE: _____