John David Reed, D.M.D.

314 Bob Wallace SW Suite A, Huntsville, AL 35801

(256) 533-6006

Patient Information/Insurance Information

Name: ____ ____________ ______

Last First Middle Initial Date of Birth Sex

____

Address City State Zip Code Home Phone Work Phone

____

Email Address

Social Security #: _________________ Marital Status _______ Occupation _______________

Employer _______________________ Business Address _______________________________

Notify in case of emergency __________________ Home/Work Phone _________________

Whom may we thank for referring you to our office? ________________________________

Primary Dental Insurance

Policy Holder ____

Relation to Patient _______________ Birthdate _____________ Soc. Sec. #___________________

Address (if different from patient) __________________________ Home Phone_________________

City ____ State _____ Zip_________________

Person Responsible Employed by _____________________________ Occupation _______________

Insurance Company ______________________ Contract # _______________ Group # ___________

Insurance Co. Address ____ Phone # _____________

Name of other dependents under this plan ____

Additional Dental Insurance

Are you covered by additional insurance? _______________

Subscriber Name _____________________ Relation to Patient ______________ Birthdate_______

Address (if different from patient) _____________________________ Soc. Sec. # _________________

City ____ State ______ Zip________________

Subscriber Employed by __________________________________ Business Phone_______________

Insurance Company ______________________ Contract # _______________ Group #____________

Insurance Co. Address ____ Phone # _____________

Authorization

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ____ Date __________________

Payment is due in full at time of treatment, unless prior arrangements have been approved.