Woodbine Dental

901 DeHirsch Ave
Woodbine, NJ 08270
(609) 861-2784

I hereby authorize the release of any information relating to all claims for benefits submitted on behalf of my dependents or myself. My signature on this document authorizes my dentist to electronically submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for my dependents and/or myself. This signature will bind me as though personally signing any particular claim. I authorize the doctor to perform work on my dependents and myself. I am the person responsible for payment to the doctor for the procedures on my dependents and myself.

_____

Date

_____

Print

_____

Signature