



David A. Goldberg, D.M.D.

Diplomate, American Board of Periodontology
Diplomate, American Board of Implant Dentistry

Adam S. Goldberg, D.D.S.

Diplomate, American Board of Periodontology
and Implant Dentistry

Authorization for Signature on File

Release of Information/Financial Responsibility/Authorization for Payment

I _____, and/or _____
Name of Patient (Parent/Guardian of Minor) (Name of Insured)

hereby authorize the office of Goldberg Implants and Periodontics to affix my name to any and all claims or documents as related to any and all health/medical/dental benefits due to me and my dependents through my insurance. This includes all correspondence regarding health/medical//dental records with my other treating doctors.

I am aware that if I need to change or cancel my appointment, there is a twenty-four (24) hour notice requirement. I understand that if cancellation occurs within the 24 hour time period, I will be charged for the broken appointment.

I will review all treatment plans and fees. I agree to be responsible for all charges for dental services and materials since my dentist does not have a contractual agreement with my plan prohibiting all or a portion of such charges. I understand that fees are due at the time of service unless other financial arrangements are made by the office staff and signed by myself. To the extent permitted under applicable law, I authorize release of any information relating to these claims.

A photocopy of this document may act as an original.

Signature of Patient



goldbergd176@hotmail.com



goldbergimplantperio.com

Today's Date



176 Cedar St. North Plainfield NJ 07060



908-756-7619



908-756-5694