Dream Dentistry & Sleep Care™
EXPERIENCE THE EXCEPTIONAL

INSURANCE SIGNATURE FORM

I authorize the release of any information needed to file my family's insurance claims. I understand that I am responsible for all costs of dental treatment.

Signature: _____

I hereby authorize payment of the dental benefit otherwise payable to me directly to Dr. Gordon S. Roeder, Jr.

Signature: _____

Date: _____

DR. GORDON S. ROEDER JR. DMD & DR. ZACHARY KULP DMD
Member: American Dental Association, American Dental Society of Anesthesiology, American Academy of Sleep Medicine

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