Benjamin Godder, D.M.D., P.C.
115 E 57 Street, Suite 1520
New York, New York 10022
(212) 750-3478

SIGNATURE ON FILE

Beneficiary Name (print) _____ Social Security Number _____

I hereby authorize payment of my Dental Insurance (_____)
Name of insurance company

benefits to Dr. Benjamin Godder.
I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my Insurance Company. I agree to pay them to Dr. Benjamin Godder.
I authorize Dr. Benjamin Godder to release any information required to process any and all claims for reimbursement on my behalf.
A copy of this authorization may be used in place of the original.

Beneficiary Signature _____ Date _____