Ramapo Oral and Maxillofacial Surgery, P.C.

ANUP MUDULI, D.M.D.

ORAL AND MAXILLOFACIAL SURGEON

180 RAMAPO VALLEY ROAD (ROUTE 202)

OAKLAND, NJ 07436

Telephone 201-337-3797 – Fax 201-337-8845

Diplomate, American Board of Oral and Maxillofacial Surgery

I authorize to release information to my insurance company for the purpose of processing claims as well as to my physician and/or dentist. I have read the Welcome To Our Practice, and fully understand that I am responsible for the balance on the account for any professional services rendered.

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**Patient’s Name**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Signature/Parent or Guardian**

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**Date**