



STATEN ISLAND  
ORAL & MAXILLOFACIAL  
SURGERY

# INSURANCE INFORMATION

**David C. Hoffman, D.D.S., F.A.C.S.**

Diplomate, American Board of Oral & Maxillofacial Surgery  
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**Lydia J. Lam, D.D.S.**

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**Steve Yusupov, D.D.S., M.D.**

Oral & Maxillofacial Surgery  
Head & Neck Surgery

Name of Insurance: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_

Policy ID #: \_\_\_\_\_ Policy Group #: \_\_\_\_\_

## ADDRESS WHERE CLAIM FORMS ARE TO BE MAILED:

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

If related to an automobile accident: D/A \_\_\_\_\_ Claim #: \_\_\_\_\_

Claims Adjuster: \_\_\_\_\_ Phone #: \_\_\_\_\_

**The following must be signed in order for this office to release information to your insurance company regarding your treatment and claim. I authorize release of any information to the insurance company relating to my claim.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(or legal guardian, if a minor)

## ASSIGNMENT OF BENEFITS GUARANTEE TO COOPERATE

I authorize, assign, and direct payment of **no-fault insurance benefits** to the office of Drs. Hoffman, Stein, and Lam for monies due on the bill(s) that relate to services rendered. I understand that neither pre-authorization nor pre-determination of benefits guarantees payment. I assign to the above medical/dental office the right to prosecute claims against the no-fault insurance carrier who affords benefits, and I agree to fully cooperate with this medical/dental provider's efforts to prosecute a claim against the no-fault insurance carrier, if there is no timely payment of the claim.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize, assign, and direct payment of **health insurance benefits** to the office of Drs. Hoffman, Stein, and Lam for monies due on the bill(s) that relate to services rendered. I understand that neither pre-authorization nor pre-determination of benefits guarantees payment. I assign to the above medical/dental office the right to prosecute claims against the health insurance carrier who affords benefits, and I agree to fully cooperate with this medical/dental provider's efforts to prosecute a claim against the health insurance carrier, if there is no timely payment of the claim.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_