STATEN ISLAND
ORAL & MAXILLOFACIAL
SURGERY

INSURANCE INFORMATION

David C. Hoffman, D.D.S.
Diplomate, American Board of Oral & Maxillofacial Surgery
Director, Oral & Maxillofacial Surgery, SIUH

Mark Stein, D.D.S., M.D.
Diplomate, American Board of Oral & Maxillofacial Surgery
Assistant Clinical Professor, NYU College of Dentistry

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

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: _____