CENTRAL NEW HAMPSHIRE
ORAL SURGERY, P.A.

Paul E. Levy, DMD
Oral and Maxillofacial Surgeon
Board Certified, Am. Bd. OMFS

INSURANCE INFORMATION

If we accept your medical/dental insurance, it is still your responsibility to pay the deductible, co-insurance, and any other balances not paid for by your insurance. We will be glad to assist you with your benefits, but you are ultimately responsible for your bill.

DENTAL INSURANCE

Primary Insurance _____ ID#_____ Group _____
Insurance Address _____ Phone # _____
Subscriber Name and Address_____
Subscriber SS# _____ Date of Birth _____ Home Phone # _____
Employer Name and Address _____
Work Phone # _____ Relationship to Subscriber_____

Secondary Insurance _____ ID#_____ Group _____
Insurance Address _____ Phone # _____
Subscriber Name and Address _____
Subscriber SS# _____ Date of Birth _____Home Phone # _____
Employer Name and Address _____
Work Phone # _____Relationship to Subscriber _____

SCHOOL INFORMATION FOR ALL DEPENDANTS OVER 18

Name _____

City _____State_____

HEALTH INSURANCE

Primary Insurance _____ ID#_____ Group _____
Insurance Address _____Phone # _____
Subscriber Name and Address _____
Subscriber SS# _____ Date of Birth _____Home Phone # _____
Employer Name and Address _____
Work Phone # _____ Relationship to Subscriber _____

Secondary Insurance _____ ID#_____ Group _____
Insurance Address _____Phone # _____
Subscriber Name and Address _____
Subscriber SS# _____ Date of Birth _____Home Phone # _____
Employer Name and Address _____
Work Phone # _____ Relationship to Subscriber _____

ASSIGNMENTS OF BENEFITS

Your signature is necessary for us to process any insurance claims, and to authorize any appropriate payment for your care.

I Authorize release of all medical information necessary to process my insurance claims. I assign all medical and /or dental benefits to which I am entitled to Central N.H. Oral Surgery, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. Your health/dental insurer and any electronic transmission clearinghouse, is to the best of our knowledge and experience, respectful of your privacy rights under HIPAA regulations.
I understand that I am financially responsible for the entire cost of my/my dependant's treatment charges. I understand that I am responsible for collections and /or attorney's charges, should a collection procedure be necessary, and as permitted under applicable N.H. Laws and Statutes, I have read this information and understand it.

Responsible Party _____ **Date** _____