Print Form

ACADIAN ORAL SURGERY
ROBERT L. LEVY D.D.S

INSURANCE AND REFERRAL INFORMATION

Who referred you to our office? We would like to thank them.

Please give the receptionist your insurance card, if available, so that she may make a copy to help us process your insurance.

Name of your Insurance:

Address of your Insurance:

Telephone # to Insurance:

Name of Policy Holder:

Policy Holder DOB: **SS#:**

Employer:

Address:

Patients Name:

Relationship to Policy Holder: self ☐ child ☐ spouse ☐

I, HEREBY AUTHORIZE DR. ROBERT L. LEVY TO RELEASE TO MY INSURANCE COMPANY, EMPLOYER, OR HIS REPRESENTATIVE ANY INFORMATION NECESSARY TO PROCESS MY CLAIM. I FURTHER AUTHORIZE ASSIGNMENT OF BENEFITS TO THE PROVIDER OF SERVICES: DR. ROBERT L. LEVY.

IN THE EVENT INSURANCE FAILS TO PAY, I UNDERSTAND I AM RESPONSIBLE FOR THE UNPAID BALANCE.

SIGNATURE OF PATIENT/ PARENT _____

DATE