PALM BEACH DIABETES & ENDOCRINE SPECIALISTS, P.A.

William A. Kaye, M.D., F.A.C.P.
Barry S. Horowitz, M.D., F.A.C.P.
Shital R. Patel, M.D.
Kathryn Reynolds, M.D
Geetanjali K. Kale, M.D., M.B.B.S.
Leslie Cotto, M.D.
Morolake Amole, M.D
Marcela Bustamante, M.D
Mayra Romina Lomonaco, M.D.
Charles Chaboude, M.S.N. APRN
Julia A. Lindower, M.S.N. APRN
Dania Manigat, D.N.P, APRN
Stephanie Devaney, MSN APRN, FNP-C
Alexis daSilva, M.D.

****Please Provide ALL Information Requested****

PATIENT INFORMATION

Name:______________________________ SSN:_____/_____/_____
Last First MI

Address:______________________ City:______________ State:________ Zip:________

Home Phone:______________ Work Phone:______________ Employer:______________

Sex:_____ Age:_____ Race:_____ Marital Status_____ Birthday:____/____/____ Occupation:______________

Referring Doctor:______________________ Which doctor are you seeing today?______________

Emergency Contact Name:______________ Phone:______________ Relationship:______________

Email Address:______________________________ Cell Phone:______________

PRIMARY INSURANCE INFORMATION

Name of insured as it appears on card:______________________________ Sex:________
Last First MI

Relation to patient:______________________ SSN:_____/_____/_____ Birthday:____/____/____

Address:______________________ City:______________ State:________ Zip:________

Home Phone:______________ Work Phone:______________ Employer:______________

PRIMARY INSURANCE COMPANY NAME:______________________________

ID#:______________________ Group/Control #:______________________ Copayment:____________

SECONDARY INSURANCE INFORMATION

Name of insured as it appears on card:______________________________ Sex:________
Last First MI

Relation to patient:______________________ SSN:_____/_____/_____ Birthday:____/____/____

Address:______________________ City:______________ State:________ Zip:________

Home Phone:______________ Work Phone:______________ Employer:______________

SECONDARY INSURANCE COMPANY NAME:______________________________

ID#:______________________ Group/Control #:______________________ Copayment:____________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with______________________________
Name of Insurance Company(ies)

and assign directly to Palm Beach Diabetes and Endocrine Specialists, P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature:______________________________ Date:______________________