# *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.
Alexis da Silva, M.D.

Marcela Bustamante, M.D
Mayra Romina Lomonaco, M.D.
NataliaViera-Feliciano, M.D.
Charles Chaboude, M.S.N. APRN
Julia A. Lindower, M.S.N. APRN
Stephanie Devaney, MSN APRN, FNP-C
Carol Kreider, M.S.N. APRN, FNP-C


****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:_____