PALM BEACH DIABETES & ENDOCRINE SPECIALISTS, P.A.

William A. Kaye, MD, FACP Shital R. Patel, MD Paul Aoun, DO, PhD Barry S. Horowitz, MD, FACP Jamie Steinsapir, MD, PhD, FACP, FACE Paul Casanova-Romero, MD, MPH, FACE Gary M. Pepper, MD,FACP Kathryn Reynolds, MD Kort Knudson, MD, FACE

Please provide ALL information requested
PATIENT INFORMATION

-				
Name:			SSN:	
	First	MI	Q.T.	77 '
Address:			ST:	
Home Phone:			Employer:	
Sex: Age: DOB:	Occupation: _			
Referring Physician:	Which Doctor	are you seeing too	lay?	
Emergency Contact:				
Name		Phone Nu		Relationship
Email Address:		Cell Phone:		
PRIMAR	RY INSURANCE I	NFORMATIC	DN	
Name of Insured as it appears on card:				Sex:
Last		First	MI	
Relation to patient:	SSN:		Birthdate:	
Address:		······································		
Home Phone:			Employer:	
PRIMARY INSURANCE COMPANY NAME:				
ID#:	Group Control	#:	Copayment:	
	-			
SECONDA	ARY INSURANCE	INFORMATI	ION	
Name of Insured as it appears on gord:				Cove
Name of Insured as it appears on card: Last		First	MI	Sex:
Relation to patient:	SSN:		Employer:	
Address:			. 1 5	
Home Phone:			Employer:	
SECONDARY INSURANCE COMPANY NAM				
		ol #:		ormant:
ID#:	Group Contro	DI #	Сор	ayment:
ASS	SIGNMENT AND	RELEASE		
I, the undersigned, certify that I (or my dependent				
1, the distributions, contribution in the depondent) nave insurance covera	50 111111	Name of Insurance Com	pany(ies)
and assign directly to Palm Beach Diabetes and Enfor services rendered. I understand that I am finan authorize the doctor to release all information necessal insurance submissions.	cially responsible for al	charges whether	or not paid by insurance	e. I hereby
Signature:		Date:		