

Pediatric Neurologists of Palm Beach

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Patient Information (Please fill out entirely)

Last Name _____ First Name _____ M.I. _____

Social Security# _____ Date of Birth ____ / ____ / ____ Sex ___ M ___ F

Address _____ City _____ State _____ Zip _____

Home Phone# _____ Referring Physician _____ MD

Emergency Contact _____ Phone# _____

Guardian Information

Mothers Name _____ Date of Birth ____ \ ____ \ ____

Social Security# _____

Address (if different than patient) _____ City _____

State _____ Zip _____ Cellular phone# _____

Employer _____ Occupation _____

Fathers Name _____ Date of Birth ____ \ ____ \ ____

Social Security# _____

Address (if different than patient) _____ City _____

State _____ Zip _____ Cellular Phone# _____

Employed by _____ Occupation _____

Primary Insurance Information

Primary Insured. Mother / Father/Other _____ Relation to patient

Insured SS# _____ (must provide) Date of Birth ____ \ ____ \ ____

Insurance Company _____

Contract# _____ Group# _____

(Please provide us with a copy of your insurance card and driver's license)

Assignment and Release:

I the undersigned certify that my dependent has insurance coverage with the above insurance company and assign payment directly to Pediatric Neurologists of Palm Beach for services rendered.

I understand I am financially responsible for all charges not paid by the insurance. I hereby authorization the doctor to release any information necessary to secure the payment of benefits. I authorization the use of this signature on all insurance submissions.

Signature _____ Date _____