Joseph M. Sperduto, MD, PA

Angel Feliciano, MD

Internal Medicine

PATIENT ID # _____ DATE:_____

Office use only

PLEASE PRINT CLEARLY

FULL NAME: _____ AGE: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

PREFERRED NUMBER FOR US TO CONTACT YOU: *(Circle one)* **HOME CELL**

EMPLOYER: _____ OCCUPATION: *(If retired, previous occupation)* _____

SPOUSE NAME: _____ SPOUSE PHONE: _____

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT NUMBER: _____ RELATION: _____

NEXT OF KIN: _____ LIVING WILL: *(Circle one)* **YES NO**

ALL PATIENTS

I, _____, understand that all copays are due at the time of my office visit. In addition, I am responsible for all remaining co-insurance and deductible balances after my claim has been submitted to my insurance company.

Patient Signature: _____

MEDICARE BEFICIARIES ONLY

I, _____, understand that Joseph M. Sperduto, MD, PA accepts Medicare assignment. I understand that I am responsible for all co-insurance and deductibles. I understand that Medicare only covers services that are deemed medically necessary. If I choose to be provided with services that Medicare does not deem as medically necessary, I understand that I will be financially responsible for those services.

Medicare Beneficiary Signature: _____