Joseph M. Sperduto, MD, PA
Angel Feliciano, MD
Internal Medicine

PATIENT ID # ____________ (Office use only)   DATE: ________________

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: ________________________