Patient Demographic Form

Please Print Legibly

CardioFit Medical Group, Inc.
Leonard J. Scuderi, M.D., F.A.C.C.

Your attention to detail when providing us with the demographic information requested will help to ensure that optimal cardiovascular healthcare is provided to you, and that your doctor(s) are provided with necessary updates regarding your current state of health. Note that if your residential, cellular, and emergency contact numbers are not updated on this form, a potentially life-threatening test result cannot be conveyed to you in a timely fashion so that you may receive prompt care.

PERSONAL DATA

NAME: _____ TITLE: ☐ Dr. ☐ Mrs. ☐ Mr. ☐ Ms. ☐ Miss
LAST FIRST MI

DATE OF BIRTH: ____/____/____ AGE: _____ GENDER: ☐ M ☐ F SSN: _____-_____-_____

ADDRESS: _____ APT #: _____
CITY STATE ZIP CODE

MARITAL STATUS: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

PHONE NUMBERS (PLEASE LIST ALL):

HOME: (_____) _____ - _____ CELL: (_____) _____ - _____

WORK: (_____) _____ - _____ FAX: (_____) _____ - _____

REFERRING PHYSICIAN DATA

PRIMARY PHYSICIAN: _____

OFFICE ADDRESS: _____
CITY STATE ZIP CODE

OFFICE PHONE: (_____) _____ - _____ OFFICE FAX: (_____) _____ - _____

If you do not provide Dr. Scuderi with your primary care physician's first and last name, phone number, and fax number, then Dr. Scuderi cannot provide your physician with vital information. Dr. Scuderi maintains a 100% compliance in providing your primary care physician with current data regarding your own cardiovascular health including providing cardiology consultation reports, follow-up office notes, laboratory tests, electrocardiograms, echocardiograms, stress tests, etc. so that your primary physician is kept apprised of your ongoing cardiovascular health status.

EMERGENCY CONTACT DATA

NAME: _____ RELATIONSHIP: _____
LAST FIRST

ADDRESS: _____ APT #: _____
CITY STATE ZIP CODE

PHONE NUMBERS (PLEASE LIST ALL):

HOME: (_____) _____ - _____ CELL: (_____) _____ - _____

WORK: (_____) _____ - _____ FAX: (_____) _____ - _____

Demographics #2

Patient Insurance Form

Please Print Legibly

CardioFit Medical Group, Inc.
Leonard J. Scuderi, M.D., F.A.C.C.

I have provided this office with my current medical insurance card(s) and certify that all of the information above is complete and accurate. I hereby authorize my insurance benefits to be paid directly to Dr. Scuderi (CardioFit Medical Group, Inc.). I realize that I am responsible to pay non-covered services, copayments, and deductibles, **including charges that go unpaid due to incomplete or inaccurate billing information if it were provided by me to this office.** I hereby authorize release of pertinent medical information to Dr. Scuderi (CardioFit Medical Group, Inc.), and to my insurance carrier(s). I understand that I may be charged $50.00 for any appointment that I either cancel or for which I neglect to show, **unless I provide at least 24 hours prior notification**, and understand that my insurance company cannot be charged.

NAME: _____ DATE OF BIRTH: ____/____/____
LAST FIRST

1st INSURANCE COVERAGE

INSURANCE COMPANY: _____ TYPE: ☐ Individual ☐ Group

SUBSCRIBER'S FULL NAME: _____
LAST FIRST

SUBSCRIBER'S DATE OF BIRTH: ____/____/____ SUBSCRIBER'S SSN: ____-____-____

INSURANCE ID #: _____ GROUP #: _____

SUBSCRIBER'S EMPLOYMENT STATUS: ☐ Employed (fill out section below) ☐ Retired ☐ Disabled

EMPLOYER: _____

WORK ADDRESS: _____
CITY STATE ZIP CODE

PATIENT'S RELATION TO SUBSCRIBER: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other

2nd INSURANCE COVERAGE

INSURANCE COMPANY: _____ TYPE: ☐ Individual ☐ Group

SUBSCRIBER'S FULL NAME: _____
LAST FIRST

SUBSCRIBER'S DATE OF BIRTH: ____/____/____ SUBSCRIBER'S SSN: ____-____-____

INSURANCE ID #: _____ GROUP #: _____

SUBSCRIBER'S EMPLOYMENT STATUS: ☐ Employed (fill out section below) ☐ Retired ☐ Disabled

EMPLOYER: _____

WORK ADDRESS: _____
CITY STATE ZIP CODE

PATIENT'S RELATION TO SUBSCRIBER: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other

Remo #2