Ph: 310-791-5577 Leonard J. Scuderi, M .D., F.A.C.C. Fx: 310-791-5575

(page 1 of 2) CardioFit Medical Group, Inc. 23441 Madison St., Bldg. 8, Suite 215

PATIENT DEMOGRAPHIC FORM

IN ORDER TO ENSURE OPTIMAL COMMUNICATION

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.

A. If your residential, cellular, and emergency contact numbers are not updated on this form, then a potentially life-threatening test result cannot be conveyed to you in a timely fashion so that you may receive prompt care.
B. If your residential address is not updated on this form, then important documents cannot be mailed to you.
C. 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 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.

Last name_ First name_ Middle name_

Title ☐ Dr. ☐ Mrs. ☐ Mr. ☐ Ms. ☐ Miss Today's date _____ - _____ - _____

Personal Data

Date of birth - - ☐ Age_ Gender ☐M ☐F SSN # - -

Address Apt/Space/Unit

City State Zip code

Type Phone numbers (please list all) E-mail address @ .

Home ( ) - ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Work ( ) - Spouse's name☐

Cell ( ) - Spouse's cell phone ( ) -

Fax ( ) - Spouse's work phone ( ) -

PATIENT DEMOGRAPHIC FORM **Leonard J. Scuderi, M.D., F.A.C.C.**

Last name First name Middle name

Occupational Data

Occupation Retired? ☐ Yes ☐ No Disabled? ☐ Yes ☐ No

Employer

Work address City State Zip code

Referring physician data

Primary physician Dr. , City State

M.D. office phone ( ) -

M.D. office fax ( ) -

Emergency contact data

Last name First name Relationship to patient

Address Apt/Space/Unit

City State Zip code (if known)

Phone numbers (please list all)

Home ( ) - Work ( ) - Cell ( ) -

Responsible party (if different from patient)

Last name First name Relationship to patient

Address Apt/Space/Unit

City State Zip code (if known)

Completed by (print name)

Completed by (signature)_____ Today's date ____-____-____