

**Carlos E. Spera M.D.**  
*Plastic and Reconstructive Surgery*

**The Crexent Business Center**  
12575 Orange Drive # 303  
Davie, FL 33330  
(954) 577-8585

**Palm Springs Center**  
1840 West 49 Street # 411  
Hialeah, FL 33012  
(305) 698-0070

**8700 Flagler Building**  
8700 West Flagler Street # 350  
Miami, FL 33144  
(305) 552-5259

**PATIENT INFORMATION**

THIS FORM MUST BE COMPLETED AND SIGNED

PATIENT NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ LAST 4 DIGITS OF SS # \_\_\_\_\_

PHONE \_\_\_\_\_ CELL \_\_\_\_\_ Email \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PERMANENT ADDRESS (if different from above) \_\_\_\_\_

DRIVER'S LICENSE # \_\_\_\_\_ (Please provide copy of Driver's License or picture ID to the office)

EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

OCCUPATION \_\_\_\_\_ SPOUSE'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_

PERSON TO CONTACT IN EMERGENCY AND /OR CAPABLE OF MAKING MEDICAL DECISIONS IF YOU

BECOME IMPAIRED \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE (work) \_\_\_\_\_

DO YOU HAVE ADVANCED DIRECTIVES? YES: \_\_\_\_\_ NO: \_\_\_\_\_

IF YES, PLEASE EXPLAIN: \_\_\_\_\_

FAMILY DOCTOR \_\_\_\_\_ PHONE \_\_\_\_\_

**HOW WERE YOU REFERRED TO THIS OFFICE:** \_\_\_\_\_

**PROCEDURE (S) INTERESTED IN:** \_\_\_\_\_

IN THE CASE THAT MY HEALTH INSURANCE IS TO BE BILLED, I AUTHORIZE DR. SPERA TO SUBMIT THE HEALTH INSURANCE CLAIM FORM , TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM, AND TO RECEIVE PAYMENT. DR. SPERA AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE HEALTH INSURANCE CARRIER AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE ONLY FOR DEDUCTIBLE, CO-INSURANCE AND NON COVERED SERVICES.

I UNDERSTAND THAT IF BY ANY CHANCE I RECEIVE ANY PAYMENT FROM MY INSURANCE COMPANY FOR SERVICES RENDERED, I AM RESPONSIBLE TO FORWARD THAT PAYMENT TO DR. SPERA.

\_\_\_\_\_  
PATIENT'S SIGNATURE (or legal representative)

\_\_\_\_\_  
DATE