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**ALDO F. BERTI, M.D., F.A.C.S., F.A.A.P.** **I**  
*Diplomate of the American Board of*  
Please contact *Neurological Surgery* or *Stereotactic Radiosurgery* at 305-661-1874. You may also contact with you promptly.

**CONTACT INFORMATION** Fields marked with \* are required

First Name \* \_\_\_\_\_

Last Name \* \_\_\_\_\_

E-mail \_\_\_\_\_

Street Address \_\_\_\_\_

Suite/Apt # \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ (drop down menu)

Zip \_\_\_\_\_

Country \_\_\_\_\_ (drop down menu)

Daytime Phone \* \_\_\_\_\_

Evening Phone \_\_\_\_\_

Are you inquiring about your self? \_\_\_\_\_

If NO , please provide Patient's Name\* \_\_\_\_\_

Relationship to you \_\_\_\_\_ (drop down menu)

What is the diagnosis?\* \_\_\_\_\_

What are the present symptoms?\* \_\_\_\_\_

Undergone surgery?\* \_\_\_\_\_

If YES, when? \_\_\_\_\_

Undergone chemotherapy?\* \_\_\_\_\_

If YES, when? \_\_\_\_\_

Undergone radiation treatment(s)?\* \_\_\_\_\_

If YES, when? \_\_\_\_\_

Physician presently caring for patient: Name \_\_\_\_\_

Specialty \_\_\_\_\_

Telephone(s) \_\_\_\_\_

Health Insurance carrier \_\_\_\_\_

Comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_