Dr. Sue Mitra, MD
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MAB
MEDICAL ASSOCIATES OF BREVARD

PATIENT INFORMATION

PATIENT INFORMATION ______ / ______ / ______ / ______ ☐ MALE ☐ FEMALE
(LAST) (FIRST) (MI) (NICKNAME)

DOB ___ / ___ / ___ SOCIAL SECURITY # ___ - ___ - ___ MARITAL STATUS: ☐ Single ☐ Married ☐ Other

ADDRESS ______ / ______ / ______
(STREET) (CITY, STATE) (ZIPCODE)

HOME PHONE ( ) - CELL PHONE ( ) - WORK PHONE ( ) -

EMAIL ADDRESS ______ @ ______

PHARMACY NAME ______ LOCATION ______

EMPLOYER ______ OCCUPATION ______

NAME OF SPOUSE OR PARENT ______

ADDRESS ______ / ______ / ______
(STREET) (CITY, STATE) (ZIPCODE)

EMERGENCY CONTACT INFORMATION

NAME ______ RELATIONSHIP ______ PHONE # ( ) -

REFERRING PHYSICIAN ______ FAMILY DOCTOR ______ PHONE # ( ) -

INSURANCE INFORMATION - PRIMARY

INSURANCE CO. ______ POLICY # ______

POLICY HOLDER NAME ______ DOB ___ / ___ / ___ S.S. # ___ - ___ - ___

INSURANCE INFORMATION - SECONDARY

INSURANCE CO. ______ POLICY # ______

POLICY HOLDER NAME ______ DOB ___ / ___ / ___ S.S. # ___ - ___ - ___

I understand that I am financially responsible for all charges for services to me, including co-payments, co-insurance, out-of pocket deductibles and non covered services. I authorize the payments from my insurance company(s) according to my medical benefits be made payable to Medical Associates of Brevard for professional services rendered. I understand that I will receive statements, reflecting my account balance and that the FINAL PAYMENT of this account is my responsibility. Furthermore should I default on payment for services rendered I agree to pay all collection costs including reasonable attorney's fee. I authorize the disclosure of my medical information to all of Medical Associates of Brevard as well as to my insurance company(s).
LIFETIME SIGNATURE AUTHORIZATION: This signature and assignment is to be a continuing one, remaining in effect until revoked in writing by the undersigned. It signifies that all information given is current.

SIGNED ______ Date ___ / ___ / ___