Dr. Sue Mitra, MD
397 N. Wickham Road, Suite 101
Melbourne, FL 32935
Phone: (321) 622-6222

MAB
MEDICAL ASSOCIATES OF BREVARD

PATIENT INFORMATION

Patient's Name _____
(Last) (First) (MI) (Nickname)

DOB ___/___/_____ Social Security # _____-____-_____ Marital Status_____

[ ] Male [ ] Female

Preferred Language: ◯ English ◯ Spanish ◯ French ◯ Indian/Hindu/Tamil ◯ Other _____

Race/Ethnicity: ◯ American Indian/Alaskan Native ◯ Native Hawaiian ◯ Black/African American ◯ White ◯ Other Pacific Islander ◯ Hispanic ◯ Non-Hispanic ◯ Other ◯ Do Not Wish To Disclose

Address _____
(Street) (City) (State) (Zip)

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____ Patient's Employer _____

Emergency Contact _____
(Name) (Phone) (Relationship)

Name of Spouse or Parent _____
(Phone)

Referring Physician _____Family Doctor_____Phone_____

IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, KINDLY GIVE OUR OFFICE 24 HOURS NOTICE TO AVOID A $25.00 FEE. THANK YOU

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 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 fees. 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 _____/_____/_____