THOMAS F. MITTS, M.D., F.A.C.S., INC.

PATIENT INTRODUCTION

(Please Print)

PATIENT'S NAME_____Age____Date of Birth_____Sex____
Last First Middle

( ) Child ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) _____

Address_____Phone_____(home)
(Number & Street) (Town) (State) (Zip)
_____(work)

Social Security #_____ e-mail address_____ _____(cell)

Patient's Employer_____Occupation_____
(Name & Address)

PARENT OR SPOUSE'S NAME_____

Parent or Spouse's Employer_____Occupation_____

PATIENT'S PRIMARY CARE PHYSICIAN_____

FRIEND OR RELATIVE NOT RESIDING WITH PATIENT:

Name_____Relationship_____
(Last) (First) (Middle)
Phone_____

Address_____
(Number & Street) (Town) (State) (Zip)

REFERRED BY:

( ) Dr _____ ( ) Magazine_____

( ) Friend _____ ( ) Internet_____

( ) Newspaper _____ ( ) Television_____

PLEASE READ THE FOLLOWING AND SIGN BELOW:

As Patient or Legal Guardian of a minor patient, I agree to pay for all services rendered at the time of my visit. I understand that this office is not contracted with any insurance companies, and unless previously discussed, does not bill insurance. In the event legal action should become necessary to enforce payment of any charges, I agree to be responsible for and pay all reasonable attorney's fees and court costs incurred.

_____ _____
(Patient or Guardian Signature) (Today's Date)