



# CONSULT FORM

SURGEON  
DR. CONSTANTINO  
MENDIETA, MD, FACS

LOCATION  
2310 SOUTH DIXIE HWY  
MIAMI, FL 33133

CONTACT  
305.860.0717  
[DOCTORMENDIETA.COM](http://DOCTORMENDIETA.COM)



Date\_\_\_\_\_

Name\_\_\_\_\_

D.O.B\_\_\_\_\_ Age\_\_\_\_\_ Sex\_\_\_\_\_

Responsible party (if minor)

Address\_\_\_\_\_ City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_

Phone\_\_\_\_\_ Cell\_\_\_\_\_ Email\_\_\_\_\_

Single Married Widow Divorced

Place of work\_\_\_\_\_ Occupation\_\_\_\_\_ Work Phone\_\_\_\_\_

In case of emergency, who should be notified\_\_\_\_\_

Contact Phone Number\_\_\_\_\_

When were you thinking of having surgery? \_\_\_\_\_

Are you interested in financing? Yes No

*I understand I am financially responsible to Dr. Constantino G Mendieta for any and all charges incurred and that such payment is not contingent upon any settlement, judgement or insurance payment.*

Signature of Patient/Responsible Party

Date

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