Fort Walton Beach
1034 Mar Walt Drive
Fort Walton Beach,
FL 32547

Destin
36474C Emerald
Coast Parkway, Suite 3101
Destin, FL 32541

Niceville
554-D Twin
Cities Boulevard
Niceville, FL 32578

Crestview
5300 South Ferdon Boulevard
Crestview, FL 32536

PATIENT INFORMATION: **E-MAIL:**____

LAST NAME:___________________________________ **FIRST:**_________________________________ **M:**_________________________

LOCAL ADDRESS:____ **CITY:**______________________ **STATE:**_______ **ZIP:**________

MAILING ADDRESS:____ **CITY:**______________________ **STATE:**_______ **ZIP:**________

SOCIAL SECURITY NO:_______________________ **DATE OF BIRTH:**__________________ **AGE:**_____________

HOME PHONE:_____________________ **CELL PHONE:**_____________________ **SEX:** □ **M** □ **F** **MARITAL STATUS:** □ **S** □ **M** □ **D** □ **W**

PREFERED LANGUAGE:	**ETHNICITY:**	**RACE:**
__Arabic __Chinese	__Hispanic or Latino	__American Indian or Alaskan Native
__English __French	__Not Hispanic or Latino	__Asian
__German __Greek	__Decline	__Black or African American
__Italian __Japanese		__Native Hawaiian or Other Pacific Islander
__Other __ Sign Language		__White
__Spanish __Vietnamese		__Decline

EMERGENCY CONTACT PERSON:____ **RELATION:**_____________________

EMERGENCY NUMBER:__________________________________

EMPLOYMENT INFORMATION: PATIENT OR PARENT

EMPLOYER:______________________________ **OCCUPATION:**_________________________ **EMPLOYEE NAME:**_________

ADDRESS:__________________________________ **CITY:**___________________________ **STATE:**_______________

ZIP CODE:___________________ **WORK PHONE:**_________________________ **EXT:**_________

RESPONSIBLE PARTY (If different from above or if patient is a minor):

NAME:____ **SOCIAL SECURITY:**_____________________________

MAILING ADDRESS:____

PHONE:________________________ **DATE OF BIRTH:**________________________ **MARITAL STATUS:**_________________

RELATION TO PATIENT: □ **SPOUSE** □ **PARENT** □ **STEP-PARENT** □ **OTHER**

HOW DID YOU HEAR ABOUT US: ____________________________

PRIMARY CARE PHYSICIAN: ________________________________ **REFERRING PHYSICIAN:**________________________________

PREFERRED PHARMACY: ____

PRIMARY INSURANCE: (Please provide copy of insurance card)

Name of Insurance _______________________________________ **Policy#** _________________________ **Group#** _______________

Name of Policy Holder ____ **Relationship to Patient**_________

PATIENT SIGNATURE: ____ **DATE:**______________________________

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