ORTHOPAEDIC ASSOCIATES
The Strength of Experience

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

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:**_____