Please fill out completely AND clearly. ALL your information is private and protected by HIPPA.

Last Name:_______________________ **First Name:**___________________ **Middle Initial**_________

(as it appears on your Florida Driver's License or Proof of Florida Residency)

_____**Male** _____**Female** (are you Pregnant- Yes / No)

Phone#:_____________________ **Email Address**:____
DOB:________________________ **Social Security #**:_______________________ **Weight**:_________
Street Address:____
City:_____________________ **State**:_______ **Zip Code**:______________ **County**:______________

How did you hear about us: **Word of mouth** __________________________ **Internet** **Street Sign**
NewsPress **FaceBook** **Radio** **Living Social** **Other**:______________________

Past Medical History: (your Medical Problems) ____
____
____

Past Surgical History: (list here or provide a list) ____
____
____

Medications: (list here or provide a list) ____
____
____

Social History: Do you smoke or vape? Nicotine/Cigarettes - yes / no Marijuana - yes / no
Do you drink alcohol more than 5 times per week? - yes / no
Do you take any drugs NOT prescribed to you? - yes / no

Allergies to Medications:____
____
____

Family History:
Mother: alive / deceased (age:______) healthy or medical history:_____________________________
Father: alive / deceased (age:______) healthy or medical history:_____________________________

Last Name:_______________________ **First Name:**___________________ **Middle Initial**_________