

PATIENT INFORMATION

Patient's Name _____ Sex _____ Date of Birth _____ S.S. No. XXX-XX - _____
Street Address _____ City and State _____ Zip _____
Home Phone _____ Work Phone _____
Employer _____
Employer Address _____ City and State _____ Zip _____
In case of emergency, contact _____ Relationship _____ Phone _____
How did you hear about Dynamic Rehab? _____

CIRCLE ONE: SPOUSE / PARENT (IF PATIENT IS A MINOR OR STUDENT)

Name _____ Home Phone _____ Work Phone _____
Street Address (if different from patient) _____ City, State _____ Zip _____
Date of Birth _____ S. S. No. _____ Employer _____

MEDICAL HISTORY - PLEASE ANSWER CAREFULLY

Reason for today's visit _____
How long have you had this problem? _____ If accident, date of injury _____
Referred by _____ Family Physician _____

PAST MEDICAL HISTORY: Do you have any previous history of:

High Blood Pressure	Y	N	Pacemaker	Y	N
Heart Condition	Y	N	Asthma	Y	N
Stroke	Y	N	Seizures	Y	N
Diabetes	Y	N	Cancer	Y	N
Orthopedic Problems	Y	N	Are you pregnant ?	Y	N

Operations (Explain) _____
Medications (List) _____

IF YOUR INJURY IS WORK RELATED

Employer at time of injury _____ Address _____
Employer Phone _____ Date of Injury _____ Claim No. _____
Name, Address, Phone of worker's comp insurance _____

IF YOUR INJURY IS RELATED TO A MOTOR VEHICLE ACCIDENT

At fault auto insurance company _____ Agent _____
Phone _____ Date of Injury _____ Claim No. _____

IF YOU HAVE RETAINED AN ATTORNEY REGARDING YOUR INJURY

Name of Attorney _____ Phone _____
Address _____

AUTHORIZATION TO RELEASE INFORMATION•ASSIGNMENT OF BENEFITS•AGREEMENT/CONTRACT

I hereby authorize Dynamic Rehab to release to the insurance company(s) and/or attorney named above any information acquired in the course of my examination or treatment (if patient is a minor, parent or guardian sign).
I hereby agree to full responsibility for all expenses incurred by or on account of this patient and hereby assign to Dynamic Rehab any and all insurance and settlement benefits due me to the full extent of my financial obligation to said clinic.
I understand my insurance coverage is a relationship between myself and my insurance company and I agree to accept financial responsibility for payment for charges incurred. I understand that in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. I understand that a \$25.00 no-show fee will be charged for each appointment that I do not give 24 hours cancellation notice.
To the best of my knowledge, the information I have given is accurate and I give permission to treat me as a patient.

Signature

Date