PATIENT INFORMATION

Patient's Name ____________________________ Sex _____ Date of Birth ______________ S.S. No. __________________

Street Address ________________________________ City and State ___________________ Zip ______________________

Home Phone ______________________________ Cell Phone _________________________________

Employer ____ Work Phone ________________________________

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**

Conditions ____

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