



**Basic Patient Information**

**Date:** \_\_\_\_\_

**First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Home Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Cell Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Sex:**  Male  Female **Email:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Marital Status:**  Single  Married  Other

**Employment Status:**  Employed  Full Time Student  Part Time Student  Other (check one)

**Employer** Company Name: \_\_\_\_\_

**Insurance Information** \*\*\* Please provide us with your insurance card to scan. \*\*\*

\*\*Please fill out if patient differs from policy holder\*\*

**Policy Holder:**  Spouse  Parent/Guardian  Other \_\_\_\_\_ **Policy Holder Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Policy Holder First Name:** \_\_\_\_\_ **MI:** \_\_\_\_ **Last Name:** \_\_\_\_\_

**Policy Holder Social Security Number:** \_\_\_\_\_

**Emergency Contact** Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

**Primary Care Physician** Name: \_\_\_\_\_ Practice Name: \_\_\_\_\_

**Treatment Authorization**

I hereby authorize this office and its staff and doctors to examine and treat my condition as the doctors deem appropriate and I give authority for these procedures to be performed. I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my behalf. Should collection of past due amount become necessary, I will become responsible for all charges, fees and attorney fees. I (we) hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

**Patients Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Acknowledgement of Receipt**

As required by the Privacy Regulation, I hereby acknowledge that I have received a current copy of the Dynamic Health and Pain Management Notice of Privacy Practices, Bill of Rights and Responsibilities.

Staff can be reached Monday-Thursday from 10am-7pm and Friday 10am-2pm at 704-525-6288. After hours call 704-525-6288 and the after hours Doctor will respond.

I am aware that the Dynamic Health and Pain Management has included a provision that it reserves the right to change the terms of this notice and to make the new notice provisions effective for all Protected Health Information that it maintains.

**Patients Name** \_\_\_\_\_

**Patient's/Representative's Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If signed by a representative of the patient:**

**Representative's Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_