Dynamic Health
4705 South Boulevard • Charlotte, NC 28217
704.525.6288 • Fax: 704.525.6384

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: _________-______-______________ (optional for Insurance purposes only)

Marital Status: ☐Single ☐Married ☐Other

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

Employer

Company Name:____

Emergency Contact

Name:_______________________Contact Number:__________________________

Primary Care Physician

Name:___ __________________Practice 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: _________________________ (optional for Insurance purposes only)

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.

Patient's 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 Notice of Privacy Practices, Bill of Rights and Responsibilities for this office.

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 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.

Patient's Signature ____**Date:**_____________

If signed by a representative of the patient:
Representative's Name __________________________________ **Relationship**________________________