Dynamic Life
Therapy & Wellness, PC

Patient Information

Legal name (first, middle, last)_____DOB:_____

Gender: Male_____ Female_____ Marital Status: _____

Height: _____ Weight: _____ Hand Dominance: ◯ Right ◯ Left

Mailing address:_____ City:_____ Zip code:_____

SSN:_____ Employer:_____ Email address:_____

Phone Home:_____ Cell : _____ Work: _____

Permission to leave a message on voicemail: Yes _____ No _____

Appointment reminders: ◯ Text message reminder ◯ Email reminder

Our office policy requests a 24-hour cancellation notice, if you are unable to make your appointment.

Policy Holder Information for Personal Insurance or Medicare

Name:_____ Date of birth_____

Address:_____

Phone Home:_____ Cell : _____ Work: _____

Relationship to Patient:_____ Gender: Male_____ Female_____

Emergency Contact

Name:_____ Relationship to patient:_____

Phone Home:_____ Cell : _____ Work: _____

◯ Patient gave permission to discuss their medical condition with emergency contact listed above

Is this treatment due to a motor vehicle or work injury? (circle one) Yes or No

Are you allergic to latex? (circle one) Yes or No

How did you hear about us?_____

Primary Physician:_____ Referring Physician:_____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPPA and has been advised that a full copy of this office's HIPPA Compliance Manual is available upon request.
The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal law.

Dated: _____, 20_____

Signature:_____
(Patient or Guardian)