PATIENT INTAKE FORM Revised 0622

TODAY'S DATE: _____

PATIENT INFORMATION

Name: _____ ____ _____
First Mi Last

Address:_____

(City)_____ **(St)**_____ **(Zip)**_____

Social security # (last 4 digits): _____

Date of birth: _____/_____/_____ **Gender: F M Age:**_____

PATIENT CONTACT INFORMATION

Home Phone: (_____) _____
Mobile: (_____) _____
Cell Carrier: _____
Email Address:_____

EMERGENCY CONTACT INFORMATION

Name: _____
Relationship: _____
Phone: _____

WORK INFORMATION

Status (please circle): Full Time Part Time Not/Un-Employed Retired Student
Job Title:_____
Company name: _____
Work address:_____
Work phone: _____x_____

INSURANCE INFORMATION

AUTO INSURANCE: (YOUR CARRIER NAME)_____ **( ) N/A**
CLAIM NO. _____ **POLICY NO.** _____
HEALTH INSURANCE CARRIER NAME:_____ **( ) N/A**
POLICY NO.:_____ **GROUP NO.:**_____

ACCIDENT PATIENTS ATTORNEY (if applicable)

FIRM NAME: _____
ATTORNEY/ CASE MGR_____

PAST/ FAMILY/ SOCIAL HISTORY (Please circle or write "NA" or "None" if none exists) ANSWER ALL QUESTIONS

1. **Marital Status** (please circle): S M D W Separated
2. **ANY** Drugs or Medications you take: _____
3. **Tobacco** use: Never / Former / Daily smoker / Some day smoker/ Other tobacco products_____
4. **Alcohol** intake: None / Occasional / Frequent (daily)
5. **ANY** conditions **YOU** have/ OR had diagnosed (Circle any that apply) OR; **NONE**
   Diabetes; Heart Disease; Cancer (type)_____; Arthritis; HIV +; Asthma/ COPD; Skin disorders (type)_____
   Any other_____
6. **FAMILY** history (blood relative): Diabetes; Heart Disease; Cancer; Arthritis; HIV +; Any other _____
7. **ANY** surgeries/ hospitalizations (include dates): **OR NONE** _____
   _____
8. Do you have a Primary care doctor? NONE **OR** Dr.'s Name/ Clinic:_____ Phone: _____
9. Any **RECENT**: Fevers; Chills; Night Sweats; UNEXPLAINED weight changes **OR ( ) NONE**
10. **Allergies**: OR **NONE**_____
11. Females: Pregnant: Y N Unsure

INFORMED CONSENT

Consent to treat patient: I hereby consent to Dynamic Care, Inc., or its agents to evaluate and treat (with physical and/or manual therapies) myself, as deemed necessary. All the information I provide is complete and accurate to the best of my knowledge. I understand that, as with any healthcare procedure, risks and complications may arise with treatment. Certain individuals may be susceptible to vascular or other tissue injuries. I shall rely on the treating physician to use her/ his best judgment based on the facts made available to her/ him.

Patient name _____ _____
Print name **Signature**

Parental consent for treatment and care of minors:[1]

I, _____ , being the parent and/or legal Guardian of the minor age child,
print adult's name

_____ , _____ , hereby give consent for necessary or
print child's name date of birth

appropriate treatment and care by the health care providers affiliated with Dynamic Care, Inc., which may include, without limitation, arranging for and/or authorizing consultation, evaluation, referral, treatment, for the above-named minor.

This consent shall remain in effect unless it is revoked in writing. Signed this _____ day of _____, 20___

Parent / Legal Guardian: _____ _____
print name sign name
Relationship to minor: _____
Address: _____
Phone: _____
*Please attach a copy of the parent/guardian valid ID or driver's license to this consent form.

[1] Authority: Sect. 1014.06, Fla. Stat.

HIPAA

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
DYNAMIC CARE, INC.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them (or declined the opportunity to read them) and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____
Patient Name (please print) Date

_____ _____
Name of Parent, Guardian or Patient's legal representative Signature of Patient, Parent, Guardian or Patient's legal representative

PRACTICE REMINDERS
By **initialing** on the lines below I authorize being contacted for practice **reminders** by:
Mail:_____ (initial) (address written above)
Email:_____ (initial) (email address written above)
Telephone: _____ **Mobile** (initial); _____ **Home** (initial) (numbers written above)
Text message _____ (initial)

ANNOUNCEMENTS
By **initialing** the lines below, I authorize being contacted for **birthday greetings, correspondence or other announcements** from the practice by:
Mail:_____ (initial) (address written above)
Email:_____ (initial) (email address written above)
Telephone: _____ **Mobile** (initial); _____ **Home** (initial) (numbers written above)
Text message _____ (initial)

PRODUCTS
By **initialing** the line below I authorize the doctor to personally discuss with me **products** that may benefit my health or condition. _____ (initial)

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____/_____ _____/_____ _____/_____

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.