PATIENT INTAKE FORM

PATIENT NAME (First, M., Last) _____ **TODAY'S DATE:** _____

Address:_____**; (City)**_____**; (St)**_____ **; (Zip)**_____

Social security # (last 4 digits): _____; Date of birth: _____; Age:_____; Gender: F M NA ; Marital Status: _____

PATIENT CONTACT INFORMATION

Home/ Mobile Phone: (_____) _____

Email Address: _____

EMERGENCY CONTACT INFORMATION

Name: _____ / Relationship: _____

Phone: _____

WORK INFORMATION: **Status: Full Time/ Part Time/ Retired/ Student/ NA; Title: _____ / Phone: _____x_____**

INSURANCE INFORMATION

HEALTH INSURANCE:_____ ( ) N/A

ID #:_____ GROUP #:_____

IF AUTO ACCIDENT: **ATTORNEY/ CASE MGR _____**

AUTO INS.: (YOUR INS. POLICY NAME)_____ ( ) N/A

POLICY # _____ CLAIM # _____

PAST/ FAMILY/ SOCIAL HISTORY (Please circle) ANSWER ALL QUESTIONS (ask if you need additional paper)

1. **ANY** Drugs or Medications you take: **OR NONE**_____
2. **Tobacco** use: Never / Former / Daily smoker / Some day smoker/ Other tobacco products_____
3. **Alcohol** intake: None / Occasional / Frequent / Daily
4. **ANY** conditions **YOU** have/ OR had diagnosed (even if unrelated to complaints OR **NONE**) _____
5. **FAMILY** history (blood relative) OR **N/A**_____
6. **ANY** surgeries/ hospitalizations (w/ dates): **OR NONE** _____
7. Do you have a Primary care doctor? NONE **OR** Dr.'s Name/ Clinic:_____ Phone: _____
8. Any **RECENT**: Fevers; Chills; Night Sweats; UNEXPLAINED weight changes **OR NONE**
9. **Allergies**: OR **NONE**_____
10. Females: Pregnant: Y N Unsure

INFORMED CONSENT

Consent to treat: I hereby consent to Dynamic Care, Inc., or its agents to evaluate and treat (with manual or other 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 their best judgment based on the facts available.

Patient name (print) _____ (Sign) _____

PARENTAL CONSENT FOR TREATMENT AND CARE OF MINORS:[1]

I, (print) _____, being the parent and/or legal Guardian of the minor child, (print) _____, (minor's date of birth)_____, hereby give consent for necessary or 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)_____ (sign)_____ **Relationship** to minor: _____

Address: _____ Phone: _____

*Provide a copy of the parent/guardian valid ID or driver's license. [1] Authority: Sect. 1014.06, Fla. Stat.