PATIENT INTAKE FORM Revised 0217

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:_____ **Work address:**_____
Company name: _____ **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.:**_____

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 of 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**

Consent to treat minor: By my signature below and as the parent, legal guardian or parentally authorized agent, I hereby authorize Dynamic Care, Inc. or its agents to evaluate and treat (with physical and/or manual therapies) the minor patient, as deemed necessary. All of 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.

Parent or Legal Guardian name _____ _____

Print name **Signature**

Mature minor treatment: : By my signature below and as the parent, legal guardian or parentally authorized agent, I hereby authorize Dynamic Care, Inc. or its agents to treat the **15, 16 or 17 year old** minor patient without my presence. I furthermore allow them to sign in/ out for related treatment. I understand I may rescind this authorization in writing at any time. I also understand that Dr. Loperfito or the treating physician will seek my approval for any treatment plan changes.

Parent or Legal Guardian name _____ _____

Print name **Signature**

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)
Facebook _____ (initial) Facebook address (if applicable)_____.

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)
Facebook _____ (initial) Facebook address (if applicable)_____.

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.