Reset Form

PATIENT INFORMATION (Must be completed)

Print Form | Submit by Email

Last Name: **First Name:** **Middle Initial** ◯ **Male** ◯ **Female**

Social Security#: **Birth Date:** ◯ **Single** ◯ **Married** ◯ **Divorced** ◯ **Widowed**

Address: **City:** **State:** **Zip Code:**

Home Phone: **Cell Phone:** **Email:**

OK to leave detailed Message? ◯ **Yes** ◯ **No**

Employer: **Occupation:** **Phone Number**

Is Patient a Minor? ◯ **Yes** ◯ **No**

OK to leave detailed Message? ◯ **Yes** ◯ **No**

If Yes: Parent/ Guardian **Home Phone:**

Emergency Contact Not Living with Patient: **Home Phone:**

Prescribing Physician: **Diagnosis:** **Supply or Treatment Needed:**

Primary Insurance: **ID Number:** **Group Number:**

Address: **City:** **State:** **Zip:**

Phone: **Subscriber:** **Subscriber Date of Birth:**

Second Insurance: **ID Number:** **Group Number:**

Address: **City:** **State:** **Zip:**

Phone Number: **Subscriber:** **Subscriber Date of Birth:**

Is this a workers Comp Claim? ◯ **Yes** ◯ **No**

Workers Comp Company:

Claim Number: **Claim Mgr:** **Phone Number:**

How did you hear about us?:

Release of Medical Information, Authorization, Acknowledgement of Financial Responsibility:

1) I authorize my physicians, doctors, nurses and other health care providers to furnish any and all information and opinions, which may be requested, regarding billing information and/or my physical condition to Dynamic Bracing and Physical Therapy, Inc (DBPT) I also authorize DBPT or any other holder of medical information about me to release to my insurance company and/or Center for Medicare and Medicaid Services and its agents any information needed to determine benefits payable for related services.

Initials:

2) I have received a copy of DBPT's financial policy and understand that I am responsible for charges associated with medical services and agree to pay all bills within 30 days from the receipt of statement, unless other arrangements have been made. I request that payment of authorized Insurance, Medicare and/or Medigap benefits be made on my behalf to DBPT for any services furnished to me by DBPT.

Initials:

3) I am insured by Medicare and have received a copy of the 25 Supplier Standards. **Initials:**

4) I certify that I have received a copy of DBPT's Notice of Privacy Act, Patient Bill of Rights and Patient Complaint Resolution.

Initials:

Signed:_____ **Date:** _____

Parent/Guardian signature if Patient is a minor.