Dynamic Health Carolinas
4705 South Blvd. | Charlotte, NC 28217 | 704-525-6288 | www.dynamichealthcarolinas.com

Basic Patient Information Date: _____

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (___) _____-_____ **Work Phone:** (___) _____-_____**Cell Phone:** (__) _____-_____

Date of Birth: _____/_____/_____ **Sex:** ☐Male ☐Female **Email:** _____

Social Security Number: _____-_____-_____ (optional for Insurance purposes only)

Marital Status: ☐Single ☐Married ☐Other

Employment Status: ☐Employed ☐Full Time Student ☐Part Time Student ☐Other (check one)

Employer Company Name:_____

Emergency Contact Name:_____Contact Number:_____

Primary Care Physician Name:___ _____Practice Name:_____

Insurance Information *** Please provide us with your insurance card to scan. ***

****Please fill out if patient differs from policy holder****

Policy Holder: ☐Spouse ☐Parent/Guardian ☐Other_____ **Policy Holder Date of Birth:** _____/_____/____

Policy Holder First Name: _____ **MI:** ___ **Last Name:** _____

Policy Holder Social Security Number: _____ (optional for Insurance purposes only)

Treatment Authorization

I hereby authorize this office and its staff and doctors to examine and treat my condition as the doctors deem appropriate and I give authority for these procedures to be performed. I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my behalf. Should collection of past due amount become necessary, I will become responsible for all charges, fees and attorney fees. I (we) hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient's Signature _____**Date:**_____

Acknowledgement of Receipt

As required by the Privacy Regulation, I hereby acknowledge that I have received a current copy of the Dynamic Medical Group Notice of Privacy Practices, Bill of Rights and Responsibilities.

Staff can be reached Monday-Thursday from 10am-7pm and Friday 10am-2pm at 704-525-6288. After hours call 704-525-6288 and the after hours Doctor will respond.

I am aware that the Dynamic Medical Group has included a provision that it reserves the right to change the terms of this notice and to make the new notice provisions effective for all Protected Health Information that it maintains.

Patient's Signature _____**Date:**_____

If signed by a representative of the patient:
Representative's Name _____ **Relationship**_____