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: _____-_____-_____ **Marital Status:** ☐Single ☐Married ☐Other

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

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: _____

Policy Holder Employer: _____

Emergency Contact Name:_____Contact Number:_____

Primary Care Physician Name:_____Practice Name:_____

Consent to Treat a Minor

I (we) being the parents, guardian or custodian of the minor being _____, Age _____, do hereby authorize, request, and direct this office, its doctors and staff to perform examinations, diagnostic X-rays, laboratory tests, and any treatment that in their judgment is deemed advisable or is required while said minor child is under care of this office's doctors and staff until legal age. All charges for services and care given to said minor child will be charged directly to me (us) and I (we) will be personally responsible for payment of them. I (we) authorize doctor to release all information necessary to secure payment of benefits. I (we) authorize the use of this signature on all insurance submissions.

Parent, Guardian or Custodian Name _____

Parent, Guardian or Custodian Signature _____ **Date:**_____

Witness _____ **Date:**_____

Acknowledgement of Receipt

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

Staff can be reached Monday-Thursday from 9am-5pm and Friday 9am-2pm at 704-525-6288. After hours call 704-525-6288 and the after hours Doctor will respond.

I am aware that the Dynamic Health Carolinas 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.

Patients Name _____

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

If signed by a representative of the patient:

Representative's Name _____ **Relationship**_____

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Initial Medical Screening Questionnaire

Name: _____ Date: _____

Recent Illness: _____ Fever: Y / N

Allergies:( ) None ( ) Penicillin ( ) Sulfa ( ) Shellfish ( ) Citrus

Medical History:

_____ _____

_____ _____

Family History: Please circle all that apply: Heart Disease Stroke Diabetes Cancer _____

Surgical History: Joint Repair/Replacement? Y / N Spine Surgery? Y / N

Please let us know if YOU HAVE or HAVE HAD any of the following conditions: (circle all that apply)

Chronic Allergies/Recent Colds/Flu/Cough	Yes	No	
Cancer of the (_____)	Yes	No	
Thyroid Problems/Chronic Steroids/Autoimmune Disease	Yes	No	
Hepatitis/ AIDS/ HIV+	Yes	No	
Diabetes	Yes	No	Recent A1C_____
Stroke / Chronic Headaches / Seizures	Yes	No	
Heart / Blood Vessel Problems	Yes	No	
Pacemaker / Cardiac Stents / Artificial Valves	Yes	No	
Chronic Blood Thinners	Yes	No	
High Blood Pressure	Yes	No	
Bone Disease / Broken Bones / Artificial Joints / Screws	Yes	No	
If Yes, Which Bones? _____			
Prostate Disease / Hormone Therapy	Yes	No	
Alcohol Addiction / Depression / Anxiety	Yes	No	
COPD/CHF/Asthma/Shortness of Breath? Wheezing/ Emphysema	Yes	No	
Recent Bronchitis/ Pneumonia/Bronchospasm	Yes	No	
Used Illegal or IV Drugs	Yes	No	
Chiropractic Treatment Before	Yes	No	
Are you or do you think you **may** be pregnant?	Yes	No	

Please explain any "YES" above:

Medications: **Please provide a written copy of ALL your medications, including ones over the counter, vitamins and supplements**