Dynamic Rehab Inc.

Patient Registration Form

Today's Date

Auto Accident ☐ Yes ☐ No

Patient Information

Patient Last Name		First	Middle	☐ Female ☐ Male		
Is this your legal name?		If not, What is your legal name?		Former Name		
Birth date	Age	Marital Status ☐ Single ☐ married ☐ Div ☐ Sep ☐ Wid				
Street Address		City	State	Zip code		
Home Phone #	Cell Phone #	Social Security #				
Date of Problem	Occupation	Employer	Employer Phone #			
Chose Clinic Because/Referred to Clinic by ☐ Dr..... ☐ Hospital ☐ Friend ☐ Yellow ☐ Family ☐ Close to Home / Work ☐ Other						
May we contact you via Email: ☐ Yes ☐ No If Yes, Email address :						
Other family members seen here?						

Insurance Information

Is this patient covered by insurance? ☐ Yes ☐ No				
Name of Primary insurance		Subscriber's Name	Birth date	
Subscriber's S.S.#		Patient's Relationship to Subscriber		
Group #	Policy #	☐ Sel ☐ Spouse ☐ Child ☐ Othe		
Co – Payment	Deductible $			
Name of Secondary insurance (If applicable)		Subscriber's Name	Birth date	
Subscriber's S.S.#		Patient's Relationship to Subscriber		
Group #	Policy #	☐ Sel ☐ Spouse ☐ Child ☐ Othe		
Co – Payment	Deductible $			
Person Responsible for bill		Birth Date Home Phone No.		
Address(if different)		Is this person a patient here?		
Occupation	Employer	Employer Address and Phone #		
Patient relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other				
Do you have an attorney for this injury? ☐Yes ☐ No		Attorney's Name :		
Attorney's Address:		Phone #		
Name of Local Friend or Relative (Not living at same address)	Relationship to Patient	Home Phone #	Cell #	

The above information is true to the best of my knowledge. I authorize my insurance benefit be paid directly to the dynamic Rehab Inc. I understand that I am financially responsible for my balance. I also authorize Dynamic rehab Inc. or insurance company to release any information required to process my claims.

Patient/Guardian Signature _____ Date _____