Dynamic Life
Therapy & Wellness, PC

Patient Information

Legal name (first, middle, last) _____ DOB: _____

Gender: ○ Male ○ Female Marital Status: _____ Preferred Name: _____

Height: _____ Weight: _____ Hand Dominance: ○ Right ○ Left

Mailling Address: _____ City: _____ Zip Code: _____

SSN: _____ Employer: _____ Email Address: _____

Phone Home: _____ Cell: _____ Work: _____

Permission to leave a message on voicemail: ○ Yes ○ No

Appointment Reminders: ☐ Text message reminder ☐ Email Reminder

Our office policy requests a 24-hour cancellation notice, if you are unable to make your appointment.

Policy Holder Information for Personal Insurance or Medicare

If different than above

Name: _____ DOB: _____

Gender: ○ Male ○ Female Relationship to Patient: _____

Mailling Address: _____ City: _____ Zip Code: _____

Phone Home: _____ Cell: _____ Work: _____

Emergency Contact

Name: _____ Relationship to Patient: _____

Phone Home: _____ Cell: _____ Work: _____

☐ Patient gave permission to discuss their medical condition with emergency contact listed above.

Is this treatment due to a motor vehicle or work injury? ○ Yes ○ No

Are you allergic to latex? ○ Yes ○ No

How did you hear about us? _____

Primary Physician: _____ Referring Physician: _____