PATIENT DEMOGRAPHICS			
NAME: Last:		First:	MI:
Mailing Address:		City:	
State:	ZIP Code:	Date of Birth:	Age:
Home Phone:		Cell Phone:	
Sex: M F	Marital Status: Single	Married Divorced	Widowed
Emergency Contact Name:		Phone Number:	

CONSENT AGREEMENT AND RELEASE	
I certify the above information is correct to the best of my knowledge. I also certify that I, and/or my dependent(s) have insurance coverage and will directly assign all insurance benefits to Dynamic Performance Physical Therapy (DPPT). I understand that I am financially responsible for all charges whether or not paid by insurance. DPPT my use may health information and may disclose such information to the insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my treatment is completed or if there are any changes in my insurance benefits.	
Patient Name:	Patient Signature:
Date:	

A copy of your medical insurance card is required for billing. *It is very important that all information be filled out completely and accurately. Insurance is considered a contract between the patient and the insurance company for reimbursement of certain medical fees. If you have medical insurance, we will bill the insurance company. However, it is your responsibility to pay deductibles, co-pays, or balances not paid by the insurance within a reasonable time.*

PRIMARY MEDICAL INSURANCE - COMPANY NAME:	
Insured: Self Spouse	Other:
Insured Birth Date: / /	Policy #:
SECONDARY MEDICAL INSURANCE – COMPANY NAME:	
Insured: Self Spouse	Other:
Insured Birth Date: / /	Policy #:
Patient Signature:	