**Dynamic Mobility & Balance Center**
**730 W Hampden Avenue, Suite 302**
**Englewood, CO 80110**

**Patient Information:**

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Sex: __ Male __ Female __ Prefer Not to Say

Phone Number: _____ cell/home/work (please circle one)
May we leave detailed voice messages at this number? ___ yes ___ no
May we text and or call for appointment reminders to this number? ___ yes ___ no

Email: _____

Occupation: _____

Emergency Contact: _____ Phone: _____

**Medical History:**

Primary Care or Referring Physician: _____

Primary Reason for Today's Visit: _____

Past/Current Medical History (please check all that apply):

___ Seizures or Epilepsy
___ Heart Disease
___ High Cholesterol
___ Diabetes
___ Bleeding Disorder
___ Asthma
___ Vertigo / Dizziness
___ Depression
___ Smoking
___ Pacemaker
___ High/Low Blood Pressure
___ Cancer
___ Neuropathy
___ Psychiatric Disorder
___ Migraines
___ Anxiety
___ Orthopedic Injury
___ Pregnancy
___ Neurological Injury (please list):

_____

_____

Other past medical problems (please list):

_____

_____

Surgical History:

_____

_____

| Medications: | Dosage: |
|---|---|
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**<u>Insurance Information:</u>**

**Primary Insurance:**

Name: _____ DOB: ____/____/_____
Relationship to patient: _____
Primary insured's name if different from patient: _____
Address: _____
City: _____ State:_____ Zip: _____
Insurance Company: _____
Insurance Phone: _____ SSN: _____
Insurance ID: _____ Group #: _____

**Secondary Insurance (if applicable):**

Name: _____ DOB: ____/____/_____
Relationship to patient: _____
Primary insured's name if different from patient: _____
Address: _____
City: _____ State:_____ Zip: _____
Insurance Company: _____
Insurance Phone: _____ SSN: _____
Insurance ID: _____ Group #: _____

**Authorization and Release:**
I authorize payment of benefits directly to **Dynamic Mobility & Balance Center** for current and future services provided. I authorize the release of any medical information necessary to process this claim and all future claims. I understand I am financially responsible for any charges not covered by this assignment including, co-payments, co-insurance, deductibles, and non-covered services. I understand I will be held responsible for any cost incurred regarding collection of payment for services rendered.

**Authorization for Treatment:**
I hereby give consent for the evaluation and ongoing treatment for services provided by my Therapist(s). I understand there are certain risks associated with my evaluation or treatment and that those risks will be presented to me during the course of my treatment. I recognize that physical therapy care may involve the touching of my body by the Practice therapists, which is expressly consented to by me.

I have read the above information and fully understand and accept the terms of this consent.

***Patient/Personal Representative Signature:*** _____

***Patient/Personal Representative Printed Name:*** _____

***Date:*** _____