

Date of Birth:	PATIENT NAME:		SS#
Mailing Address: City State Zip Code Home/Cell E-Mail**: ** By providing your email you will be automatically enrolled to receive appointment reminders as well as monthly statements via email from mre EMR Provider WEBPT. (Quarterly statements will be sent via Letter USPS Math). *** **Mother insurance/ financial/statement questions and accommodations can be taken care of by Sandy, our in house insurance specialist. **Emergency Contact:* Phone Number: Relation: **Employer & Occupation Description:* Address: City State Zip Phone Number: Supervisor: **Employer & Occupation Description:* Address: City State Zip Phone Number: Guarantor Insurance: Policy/ID Number: Guarantor Name: Guarantor Name: Guarantor Date of Birth: / / Guarantor Date of Birth: / / Address State Signary insurance carrier. **Referring Physician: Phone Number: Cherchy assign payment from any state/federal, commercial, or employer-related insurance to Dynatest, Inc. that are, otherwise, applicable to me out not to exceed their charges. I understand I am financially responsible to Dynatest, Inc. the are, otherwise, applicable to me out not to exceed their charges. I understand I am financially responsible to Dynatest, Inc. the are, otherwise, applicable to me out not to exceed their charges. I understand I am financially responsible to Dynatest, Inc. for services rendered. I also understand I am financially responsible to Dynatest, Inc. for services rendered. I also understand I am financially responsible to Dynatest, Inc. for services rendered. I also understand I am financially responsible to Dynatest, Inc. for services rendered. I also understand I am financially responsible to Dynatest, Inc. for services rendered. I also understand I am financially responsible to Dynatest, Inc. for services rendered. I also understand I am financially responsible to Dynatest, Inc. for services rendered. I also understand I am financially responsible to Dynatest, Inc. for services rendered. I also understand I am financially responsible	Date of Birth://	Sex: Male/Female	Marital Status: Married/Single
City			
Phone Number:	City	StateZip Code	
thereby authorize Dynatest, Inc. to release information requested by my insurance carrier and/or employer's insurance carrier. Chereby authorize Dynatest, Inc. to release information requested by my insurance to Dynatest, Inc. the that are, otherwise, applicable to me pair not to texceed their charges. Inc. for farges not covered authorized by my insurance to Dynatest, Inc. that hat regardless of what type of insurance larry, some services that I receive as services readered. I also understand that in viacetical that my signature below shall indicate that the information provided above is accurate as well as my agreement to the above. Patient/Guarantor Signature: Date of Signature: Patient/Guarantor Signature: Date of Signature:	Phone Number:	Home/Cell	
thereby authorize Dynatest, Inc. to release information requested by my insurance carrier and/or employer's insurance carrier. Chereby authorize Dynatest, Inc. to release information requested by my insurance to Dynatest, Inc. the that are, otherwise, applicable to me pair not to texceed their charges. Inc. for farges not covered authorized by my insurance to Dynatest, Inc. that hat regardless of what type of insurance larry, some services that I receive as services readered. I also understand that in viacetical that my signature below shall indicate that the information provided above is accurate as well as my agreement to the above. Patient/Guarantor Signature: Date of Signature: Patient/Guarantor Signature: Date of Signature:	E-Mail**:		
All other insurance/ financial/statement questions and accommodations can be taken care of by Sandy, our in house insurance specialist. Emergency Contact: Phone Number: Relation: Employer & Occupation Description: City State Zip Phone Number: Supervisor: Primary Insurance: Policy/ID Number: Guarantor Name: Guarantor Name: Guarantor Name: Guarantor Date of Birth: Guarantor Date of Birth:	** By providing your email you will be automatically	enrolled to receive appointment reminder	s as well as monthly statements via email from
Emergency Contact: Phone Number: Relation: Employer & Occupation Description: Address: City State Zip Phone Number: Supervisor: Primary Insurance: Policy/ID Number: Guarantor Name: Guarantor Name: Guarantor Name: Guarantor Date of Birth: Beferring Physician: Date last seen: I hereby authorize Dynatest, Inc. to release information requested by my insurance carrier and/or employer's insurance carrier. It hereby assign payment from any state/federal, commercial, or employer-related insurance to Dynatest, Inc. that are, otherwise, applicable to me but not to exceed their charges. I understand I am financially responsible to Dynatest, Inc. for services rendered. I also understand I am financially responsible to Dynatest, Inc. for services rendered. I also understand I am financially responsible to Dynatest, Inc. for services rendered. I also understand I am financially responsible to Dynatest, Inc. for services rendered. I also understand I am financially responsible to Dynatest, Inc. for services rendered. I also understand I am financially responsible to Dynatest, Inc. that are, otherwise, applicable to me but not to exceed their charges. I understand I am financially responsible to Dynatest, Inc. for services rendered. I also understand I am financially responsible to Dynatest, Inc. for services rendered. I also understand I am financially responsible to Dynatest, Inc. for services rendered. I also understand I am financially responsible for payment. It understand that my signature below shall indicate that the information provided above is accurate as well as my agreement to the above.	our EMR Provider WEBP1. (Quarterly statements w	ui be sent via Letter USPS Maii).	
Phone Number: Employer & Occupation Description: City State Zip Phone Number: Supervisor: Primary Insurance: Policy/ID Number: Guarantor Name: Guarantor Name: Guarantor Date of Birth: Date last seen:	All other insurance/ financial/statement questions an	d accommodations can be taken care of b	y Sandy, our in house insurance specialist.
Phone Number: Employer & Occupation Description: City State Zip Phone Number: Supervisor: Primary Insurance: Policy/ID Number: Guarantor Name: Guarantor Name: Guarantor Date of Birth: Date last seen:			
Relation: Employer & Occupation Description: Address: City State Zip Phone Number: Supervisor: Primary Insurance: Policy/ID Number: Guarantor Name: Guarantor Name: Guarantor Date of Birth: Date last seen: I hereby authorize Dynatest, Inc. to release information requested by my insurance carrier and/or employer's insurance carrier. It hereby assign payment from any state/federal, commercial, or employer-related insurance to Dynatest, Inc. that are, otherwise, applicable to me but not to exceed their charges. I understand I am financially responsible to Dynatest, Inc. for services rendered. I also understand I am financially responsible to Dynatest, Inc. for services rendered. I also understand I am financially responsible to Dynatest, Inc. for services that I receive that I receive may not be covered under my plan. I understand that it receive a service not covered by my insurance, I will be held responsible for payment. I understand that my signature below shall indicate that the information provided above is accurate as well as my agreement to the above. Patient/Guarantor Signature: Date of Signature:	Emergency Contact:		
Address: City	Polotion		
Address: City	Kelauon:		
Address: City	Employer & Occupation Description		
Address:			
Primary Insurance: Secondary Insurance: Policy/ID Number: Guarantor Name: Guarantor Name: Guarantor Date of Birth:			State Zip
Primary Insurance: Policy/ID Number: Guarantor Name: Guarantor Name: Guarantor Date of Birth: Phone Number:			
Policy/ID Number: Guarantor Name: Guarantor Date of Birth: Guarantor Date of Birth: Guarantor Date of Birth: Guarantor Date of Birth: Guarantor Date of Birth: Guarantor Date of Birth: Phone Number:			
Policy/ID Number: Guarantor Name: Guarantor Date of Birth: Guarantor Date of Birth: Guarantor Date of Birth: Guarantor Date of Birth: Guarantor Date of Birth: Guarantor Date of Birth: Phone Number:	Primary Insurance:	Secondary Insurance:	
Referring Physician:			
Referring Physician:			
I hereby authorize Dynatest, Inc. to release information requested by my insurance carrier and/or employer's insurance carrier. I hereby assign payment from any state/federal, commercial, or employer-related insurance to Dynatest, Inc. that are, otherwise, applicable to me but not to exceed their charges. I understand I am financially responsible to Dynatest, Inc. for services rendered. I also understand I am financially responsible to Dynatest, Inc. for charges not covered/authorized by my insurance and/or employer's insurance carrier. I understand that regardless of what type of insurance I carry, some services that I receive may not be covered under my plan. I understand that it receive a service not covered by my insurance, I will be held responsible for payment. I understand that my signature below shall indicate that the information provided above is accurate as well as my agreement to the above. Patient/Guarantor Signature:	Guarantor Date of Birth:/	/ Guarantor D	oate ofBirth://
I hereby authorize Dynatest, Inc. to release information requested by my insurance carrier and/or employer's insurance carrier. I hereby assign payment from any state/federal, commercial, or employer-related insurance to Dynatest, Inc. that are, otherwise, applicable to me but not to exceed their charges. I understand I am financially responsible to Dynatest, Inc. for services rendered. I also understand I am financially responsible to Dynatest, Inc. for charges not covered/authorized by my insurance and/or employer's insurance carrier. I understand that regardless of what type of insurance I carry, some services that I receive may not be covered under my plan. I understand that it receive a service not covered by my insurance, I will be held responsible for payment. I understand that my signature below shall indicate that the information provided above is accurate as well as my agreement to the above. Patient/Guarantor Signature:			
I hereby authorize Dynatest, Inc. to release information requested by my insurance carrier and/or employer's insurance carrier. I hereby assign payment from any state/federal, commercial, or employer-related insurance to Dynatest, Inc. that are, otherwise, applicable to me but not to exceed their charges. I understand I am financially responsible to Dynatest, Inc. for services rendered. I also understand I am financially responsible to Dynatest, Inc. for charges not covered/authorized by my insurance and/or employer's insurance carrier. I understand that regardless of what type of insurance I carry, some services that I receive may not be covered under my plan. I understand that it receive a service not covered by my insurance, I will be held responsible for payment. I understand that my signature below shall indicate that the information provided above is accurate as well as my agreement to the above. Patient/Guarantor Signature:	n e · nı · ·	DI .	NT 1
I hereby authorize Dynatest, Inc. to release information requested by my insurance carrier and/or employer's insurance carrier. I hereby assign payment from any state/federal, commercial, or employer-related insurance to Dynatest, Inc. that are, otherwise, applicable to me but not to exceed their charges. I understand I am financially responsible to Dynatest, Inc. for services rendered. I also understand I am financially responsible to Dynatest, Inc. for charges not covered/authorized by my insurance and/or employer's insurance carrier. I understand that regardless of what type of insurance I carry, some services that I receive may not be covered under my plan. I understand that it receive a service not covered by my insurance, I will be held responsible for payment. I understand that my signature below shall indicate that the information provided above is accurate as well as my agreement to the above. Patient/Guarantor Signature: Date of Signature:	Referring Physician:	Pnone Number:	
I hereby assign payment from any state/federal, commercial, or employer-related insurance to Dynatest, Inc. that are, otherwise, applicable to me but not to exceed their charges. I understand I am financially responsible to Dynatest, Inc. for charges not covered/authorized by my insurance and/or employer's insurance carrier. I understand that regardless of what type of insurance I carry, some services that I receive may not be covered under my plan. I understand that is I receive a service not covered by my insurance, I will be held responsible for payment. I understand that my signature below shall indicate that the information provided above is accurate as well as my agreement to the above. Patient/Guarantor Signature:	Date last seen://		
I hereby assign payment from any state/federal, commercial, or employer-related insurance to Dynatest, Inc. that are, otherwise, applicable to me but not to exceed their charges. I understand I am financially responsible to Dynatest, Inc. for charges not covered/authorized by my insurance and/or employer's insurance carrier. I understand that regardless of what type of insurance I carry, some services that I receive may not be covered under my plan. I understand that is I receive a service not covered by my insurance, I will be held responsible for payment. I understand that my signature below shall indicate that the information provided above is accurate as well as my agreement to the above. Patient/Guarantor Signature:			
I hereby assign payment from any state/federal, commercial, or employer-related insurance to Dynatest, Inc. that are, otherwise, applicable to me but not to exceed their charges. I understand I am financially responsible to Dynatest, Inc. for charges not covered/authorized by my insurance and/or employer's insurance carrier. I understand that regardless of what type of insurance I carry, some services that I receive may not be covered under my plan. I understand that is I receive a service not covered by my insurance, I will be held responsible for payment. I understand that my signature below shall indicate that the information provided above is accurate as well as my agreement to the above. Patient/Guarantor Signature:	hereby authorize Dynatest. Inc. to release information	n requested by my insurance carrier and/or	employer's insurance carrier.
but not to exceed their charges. I understand I am financially responsible to Dynatest, Inc. for services rendered. I also understand I am financially responsible to Dynatest, Inc. for charges not covered/authorized by my insurance and/or employer's insurance carrier. I understand that regardless of what type of insurance I carry, some services that I receive may not be covered under my plan. I understand that it receive a service not covered by my insurance, I will be held responsible for payment. I understand that my signature below shall indicate that the information provided above is accurate as well as my agreement to the above. Patient/Guarantor Signature:			1 7
financially responsible to Dynatest, Inc. for charges not covered/authorized by my insurance and/or employer's insurance carrier. I understand that regardless of what type of insurance I carry, some services that I receive may not be covered under my plan. I understand that is receive a service not covered by my insurance, I will be held responsible for payment. I understand that my signature below shall indicate that the information provided above is accurate as well as my agreement to the above. Patient/Guarantor Signature:			
I understand that regardless of what type of insurance I carry, some services that I receive may not be covered under my plan. I understand that it receive a service not covered by my insurance, I will be held responsible for payment. I understand that my signature below shall indicate that the information provided above is accurate as well as my agreement to the above. Patient/Guarantor Signature: Date of Signature:			
I understand that my signature below shall indicate that the information provided above is accurate as well as my agreement to the above. Patient/Guarantor Signature: Date of Signature:	I understand that regardless of what type of insurance	I carry, some services that I receive may no	
Patient/Guarantor Signature:	I receive a service not covered by my insurance, I will	be held responsible for payment.	
Date of Signature://	I understand that my signature below shall indicate tha	at the information provided above is accurat	e as well as my agreement to the above.
Date of Signature://			
Date of Signature://			
Date of Signature://			
Date of Signature://	Patient/Guarantor Signature:		
		arty)	