DYNATEST, INC.

Demographic Information

PATIENT NAME:_____**SS#**_____-_____-_____
Date of Birth:_____/_____/_____ **Sex:** Male/Female **Marital Status:** Married/Single
Mailing Address:_____
City_____ **State**_____**Zip Code**_____
Phone Number:_____ 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 our EMR Provider WEBPT. (Quarterly statements will be sent via Letter USPS 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:_____
_____
Address:_____**City**_____**State**_____**Zip**_____
Phone Number:_____**Supervisor:**_____

Primary Insurance:_____**Secondary Insurance:**_____
Policy/ID Number:_____**Policy/ID Number:**_____
Guarantor Name:_____**Guarantor Name:**_____
Guarantor Date of Birth:_____/_____/_____ **Guarantor Date ofBirth:**_____/_____/_____

Referring Physician:_____**Phone Number:**_____
Date last seen:_____/_____/_____

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 if 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 of Signature:_____/_____/_____
(If patient is a minor, must be signed by responsible party)