Payment Received ☐

Forms Completion Request

***** to be completed by patient for each form request *****

A $20 fee is required to complete all FMLA and DBL forms. A $10 fee is required to complete all other forms.
Please allow 10 business days to complete this request.

SECTION I – PERSONAL DATA **Today's Date:** ______________

Patient Name: ______________________________ DOB: ______________________

Which provider do you see? ____

Once this form is complete please advise on how you would like us to handle:

☐ I would like to pick this up, please call me at: ______________________________

☐ Please Fax this form to (name and fax number): ____________________________

☐ Please Mail this form to (name and address): ______________________________

____

SECTION II – RECORDS RELEASE

I hereby authorize Dent Neurologic Institute to release my medical information as requested on the attached form and to distribute as indicated in Section I.

___________________________________ _____________________

Patient Signature **Date**

Section III – DISABILITY/WORK CAPACITY/FMLA

Date Symptoms Began: _____________ Date Diagnosis Made: ____________________

Date Disability Began: _______________Last Day Worked: _______________________

Diagnosis for Disability: ____

If working part–time, date begun: ____
(Hours/Days, or Days/Week)

Current Work Restrictions: ____

____

____

(SEE REVERSE SIDE)

Employer/Job Title: ____

If you are not currently working, who certified work disability?

____

When? ___________________ Short Term: __________ Long Term: ____________

Why are you disabled (what can you not do home/work)? ________________________

____

____

____

List cognitive/memory problems: ____

____

____

____

____

Carrier Representative Name: ____

Phone #:_________________________________Fax #:__________________________

Additional Information:

____

____

____

____

____

Signature: ___________________________________ Date: _______________

Please Print Name: _____________________________ DOB: _______________