DENT NEUROLOGIC INSTITUTE

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: _____