DENT NEUROLOGIC INSTITUTE

Payment Received ☐

to be completed by patient for each form request*
Please allow 10 business days to complete this request.

Forms Completion Request

FORMS PRICES:
DBL $20
PFL $25
DMV (pt request) $25
FMLA $40
Life Insurance $30
ADA $25
NYS EDU $15
All Other $10:
(additional $10 beyond 2 pages)

SECTION I – PERSONAL DATA Today's Date: _____

Patient Name: _____ DOB: _____

Which provider do you see at Dent? _____

If we have questions, what is the best number to reach you at? _____

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

☐ I will pick the form up; call me at: _____

☐ Fax this form to _____ ATTN: _____

☐ Mail this form to (name) _____ (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**

DISABILITY/WORK CAPACITY/FMLA CONTINUED…

Employer/Job Title: _____

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

When? _____ Short Term ☐ Long Term ☐

Reason for disability; what are you unable to do at home and/or work? _____
_____
_____

List any cognitive/memory problems: _____
_____
_____

SECTION III – DISABILITY/WORK CAPACITY/FMLA

Date symptoms began: _____

Date diagnosis was made: _____

Date disability began: _____

Last date worked: _____

Diagnosis for disability: _____

If working part-time, date begun: _____
(hours/days, or days/week)

Current work restrictions: _____
_____
_____

CARRIER REPRESENTATIVE NAME:
_____

Phone: _____

Fax: _____

Please note your "requests" here regarding your restrictions (hours/days, weeks/months, etc.) ***Subject to providers review and approval if appropriate*** _____
_____

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