

# Horizon Balance and Dizziness Center

Please **fill out ALL** information completely.

## Patient Information

Patient's Full Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Birthday: \_\_\_\_\_ Age: \_\_\_\_\_  
Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_  
Social Security # \_\_\_\_\_ Height: FT \_\_\_\_\_ Inches \_\_\_\_\_  
Employer: \_\_\_\_\_ Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ Retired \_\_\_\_\_ N/A \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Employer Phone # \_\_\_\_\_ Supervisor: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_  
Phone#: \_\_\_\_\_ Relationship: \_\_\_\_\_  
How did you find out about our clinic? \_\_\_\_\_

## Insurance Information

**Primary Insurance:** \_\_\_\_\_  
Copay \$ \_\_\_\_\_ (Due at time of service)  
Annual Deductible \$ \_\_\_\_\_ Amount Met \$ \_\_\_\_\_  
Primary Insured Name: \_\_\_\_\_  
Date of Birth of primary insured: \_\_\_\_\_ Primary Insured SS # \_\_\_\_\_  
Relationship to insured: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_

## Injury/ Illness Information

(Required to fill out ALL of the following for insurance purposes)

Diagnoses/Complaint: \_\_\_\_\_ Onset Date: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_  
Date of last physician appointment: \_\_\_\_\_  
Date of next physician appointment: \_\_\_\_\_  
(Medicare patients must see referring physician every 30 days while receiving physical therapy)

\*I acknowledge the above information is complete and correct, I understand that I may be asked for further information for treatment and billing purposes. I give full consent to any physical therapy treatment or procedure deemed necessary by this clinic for my condition. I authorize Horizon Balance and Dizziness Center to release any information concerning this course of treatment from medical records.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Parent of Patient: \_\_\_\_\_  
(If patient is under 18 years of age)