**Horizon Balance and Dizziness Center**

**Please fill out *ALL* information completely.**

**Patient Information**

Patient’s Full Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_

 Birthday:\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_Sex:\_\_M\_\_\_F Social Security#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Married\_\_ Single \_\_ Divorced \_\_ Widowed \_\_Height\_\_\_\_\_\_Weight\_\_\_\_\_\_

 Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_

Home Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Full Time\_\_\_ Part Time\_\_\_ Retired\_\_\_\_ N/A\_\_\_\_

Employer Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1 Have you had any home health Care? Yes No Are you still having it? Yes No

2. Have you had Physical Therapy this year? Yes No Are you still going? Yes No

3. Was this a injury and if so was it an Auto or Workers comp injury? Yes No

\*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)