PATIENT INFORMATION QUESTIONNAIRE

PERSONAL INFORMATION:

Name:_____ ☐ MALE ☐ FEMALE
First M. Last
Address:_____ Apt/Unit#: _____ City_____

State: _____ Zip Code: _____ Home Phone:_____ Work Phone:_____

Mobile Phone: _____ Email Address: _____

SS#:_____-_____-_____ Date of Birth: ____/____/_____ Age:_____ Marital Status: _____

IN CASE OF EMERGENCY, CONTACT:_____ Phone:_____

EMPLOYMENT STATUS: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed

Employer:_____

Address:_____ City:_____

State:_____ Zip Code:_____

MEDICAL DOCTOR INFORMATION:

Referring Physician:_____ Phone: ( ) ____-_____

Address:_____City:_____ State:_____ Zip Code:_____

Family Physician:_____ Phone: ( )_____-_____

PLEASE STATE BRIEFLY THE NATURE OF YOUR PROBLEM:_____
PLEASE LIST OPERATIONS YOU HAVE HAD:_____
PLEASE NAME ANY MEDICATIONS YOU ARE ALLERGIC TO OR HAVE BEEN ADVISED NOT TO TAKE:_____

PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE HAD OR CURRENTLY HAVE:

☐ Heart Disease ☐ Glaucoma ☐ Stroke ☐ Nausea ☐ Artificial Joints ☐ Ulcer Disease
☐ Depression ☐ Cancer ☐ Pacemaker ☐ Asthma ☐ Arthritis ☐ Back Problems
☐ Tuberculosis ☐ Diabetes ☐ Neck Problems ☐ Emphysema or COPD ☐ Infection/Wounds ☐ Blood Disorders
☐ Breathing Problems ☐ High Blood Pressure ☐ Parkinson's Disease ☐ Ringing In Ears ☐ Circulation Problems ☐ Epilepsy or Convulsions
Other:_____

ACKNOWLEDGEMENT OF PAYMENT (CHECK ALL THAT APPLY)

☐ Cash ☐ Check ☐ Visa ☐ MasterCard ☐ Discover
☐Primary Insurance:_____ _____ _____
Name of Insurance ID # Group#
☐Secondary Insurance:_____ _____ _____
Name of Insurance ID # Group#

I understand that I am ultimately responsible for the balance on my account for any professional services rendered. I authorize your office to release any information relating to the services obtained here and those services related to my treatment here to other professionals and insurers as may become necessary. I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to the undersigned physician or supplier for services described.

AUTHORIZATION FOR TREATMENT

The patient /legal guardian authorized The American Institute of Balance staff to administer appropriate testing and/or treatment for the patient's diagnosis/rehabilitation. The patient/legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.

Signature:_____ Date:_____