

PATIENT

INFORMATION

QUESTIONNAIRE

PERSONAL INFORMATION :

Name : _____ MALE FEMALE
 First M. Last
 Address : _____ Apt/Suite : _____
 City : _____ State : _____ Zip Code : _____
 Home Phone : () _____ - _____ Work Phone : () _____ - _____ EXT. _____
 SS # : _____ - _____ - _____ DOB : ____/____/____ AGE : _____ Marital Status : _____
 IN CASE OF EMERGENCY, CONTACT : _____ Phone : _____

EMPLOYMENT STATUS :

Full Time Part Time Retired None
 Employer : _____
 Address : _____ Suite : _____
 City : _____ State : _____ Zip Code : _____

MEDICAL DOCTOR INFORMATION :

Referring Dr : _____ Phone : () _____ - _____
 Address : _____ Suite _____ UPIN _____
 City : _____ State : _____ Zip Code : _____
 Family Dr : _____ Phone () _____ - _____

PLEASE STATE BRIEFLY THE NATURE OF YOUR PROBLEM : _____

LIST MEDICATIONS YOU ARE TAKING : _____

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 now have :

- Heart Disease Glaucoma Stroke Nausea Artificial Joints
- Ulcer Disease Depression Cancer Back Problems Multiple Sclerosis
- Blood Disorders Pacemaker Asthma Neck Problems Emphysema / COPD
- Infection / Wounds Tuberculosis Arthritis Breathing Problems High Blood Pressure
- Parkinson's Disease Ringing in ears Diabetes Circulation Problems Epilepsy/Convulsions

ACKNOWLEDGEMENT OF PAYMENT (CHECK ALL THAT APPLY)

- Cash Check Visa MasterCard Discover

	Name	Number	Group
<input type="radio"/> Primary Insurance :	_____	_____	_____
<input type="radio"/> Secondary Insurance :	_____	_____	_____

Other insurance's are not accepted unless previous arrangements have been made.

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 authorizes 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 :** _____

