



360° Balance

Specializing in dizziness, balance and hearing disorders.

PATIENT REGISTRATION FORM

Date: _____

Patient Information: (Please Print)

Patient's Name: _____ Social Security #: _____
First Middle Initial Last

Address: _____
Street Address City State Zip

Home Phone: (_____) _____ Gender: M F Age: _____ Date of Birth: _____

Marital Status: Single Married Divorced Separated

Employer: (If Applicable) _____ Occupation: _____

Business Phone: (_____) _____ Cell Phone: (_____) _____

Employer's Address: _____
Street Address City State Zip

E-mail Address: _____

In case of emergency Please Contact: _____ Relation: _____ Phone: (_____) _____

How did you hear about our clinic? _____

Insurance Information:

Insurance Primary Cardholder: (If Person Other Than Yourself) _____ D.O.B.: _____

Social Security #: (If Primary Cardholder Is Person Other Than Yourself) _____

Primary Cardholder Employer: (If Applicable) _____ Bus. Phone: _____

If Patient is a Minor:

Legal Guardian's Name: _____ Soc. Sec. #: _____
First Last MI

Address: _____
Street Address City State Zip

Home Phone: _____ Business Phone: _____ Birthdate: _____

Reason for Consultation:

Reason for Consultation: _____

Referring Doctor: _____ Phone: _____ Date of Last Visit with Referring Doctor: _____

Family Physician: _____ Phone: _____

Medicare Patients Only:

Have you received physical or occupational therapy from another provider during this calendar year? Yes No

Are you currently receiving any home health services (ex. PT, OT, Speech, Nursing, etc.)? Yes No

Consent of Treatment, Authorization to Release Information and Notice of Privacy Practices:

I hereby authorize 360 Balance through its appropriate personnel, to furnish medical care and treatment to me, or the above named patient, considered necessary and proper in diagnosing or treating my/his/her physical condition. I further authorize 360 Balance to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided. I acknowledge that I have been advised of this office's Notice of Privacy Practices. I understand that I am entitled to receive a copy of this document upon request.

Signature: _____ (relationship to patient: self - guardian - other: _____) Date: _____