WHIDBEY DIZZINESS & BALANCE

Patient Information

LEGAL NAME _____ REASON FOR VISIT _____

PREFERRED NAME _____ DATE OF ONSET _____

HOME ADDRESS _____ REFERRING DOCTOR _____

CITY/STATE _____ ZIP _____ DOCTOR'S PHONE _____

BIRTHDATE _____ PRIMARY DOCTOR _____

SEX ☐ FEMALE ☐ MALE ☐ OTHER _____ DOCTOR'S PHONE _____

GENDER ☐ FEMALE ☐ MALE ☐ TRANSGENDER EMERG.CONTACT _____

☐ NON-BINARY ☐ ADDITIONAL: _____ RELATION TO YOU _____

PROUNOUNS ☐ THEY/THEM ☐ SHE/HER ☐ HE/HIM CONTACT'S PHONE _____

SELECT 2 PREFERRED CONTACT METHODS FOR REMINDERS

PREFERRED PHONE _____

PREFERRED EMAIL _____

HOW DID YOU LEARN ABOUT US?

☐ HEALTHCARE PROVIDER ☐ FAMILY/FRIEND

☐ INTERNET ☐ EVENT ☐ OTHER: _____

If treatment relates to an Auto or Work-related injury, please provide the information below.

Auto/L&I Information

INSURANCE COMPANY _____

CLAIM NUMBER _____

ADDRESS _____

CITY/STATE _____ ZIP _____

ADJUSTOR'S NAME _____

PHONE NUMEBER _____

Attorney Information

NAME _____

FIRM _____

PHONE _____

Consent to Treat

I authorize treatment of the patient named above and agree to pay all charges for such treatment that may or may not be covered by insurance. I also authorize Whidbey Dizziness & Balance to release any information to referring/consulting healthcare providers that may be necessary to facilitate care. I certify that a copy of this agreement shall be valid as the original.

_____ _____

Signature of Patient or Legal Guardian Date

WHIDBEY DIZZINESS & BALANCE

Financial Policy

Please read carefully and sign

Whidbey Dizziness & Balance, PLLC does not contract with Medicare or any other form of health insurance. Services must be paid in full at the time of your appointment. At your request, we will provide you with an itemized bill of services rendered that you may submit to your insurance. It is your responsibility to know the limitations and restrictions of your insurance company's out-of-network benefits. We have provided a *Benefits Script* on our website to help guide you in that process (www.whidbeydizzy.com/forms).

Missed Appointments and Cancellations

Appointments missed or cancelled without ***24 hours-notice*** prior to the scheduled appointment time will be charge 50% of the original service fee. Late arrivals will be charged for the full scheduled length of your appointment. These charges cannot be billed to your insurance and must be paid at your next scheduled appointment. If you miss ***3 appointments*** without proper notice, we reserve the right to cancel all future appointments.

_____ _____

Signature of Patient or Legal Guardian Date

Privacy Policy

Whidbey Dizziness & Balance (WDB) Notice of Privacy Practices can be obtained from our website or requested at our clinic (www.whidbeydizzy.com/forms).

Acknowledgement of Notice of Privacy Practices

I acknowledge that I have received *Whidbey Dizziness & Balance Notice of Privacy Practices* and consent to the use and disclosure of my information for the purposes described in this document to the extent permitted by law. This includes, but is not limited to, sharing appointment reminders and personal health information by way of (check all that apply):

- ☐ My preferred **phone number as indicated on my New Patient Intake form**
- ☐ My preferred **email** as indicated on my New Patient Intake form
- ☐ The following **person(s)**:

Photo/Video Consent

- ☐ I agree to my **photograph** being taken for use on the company's website or social media.
- ☐ I agree to **video** being taken of me for use on the company's website or social media.

_____ _____

Signature of Patient or Legal Guardian Date

WHIDBEY DIZZINESS & BALANCE

Patient Health History

Name: Age: Height: Weight:

Medical History (check all that apply)

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Arthritis
- ☐ Cancer
- ☐ COPD
- ☐ Chest pain
- ☐ Depression
- ☐ Diabetes
- ☐ Falls
- ☐ Hearing loss
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Migraine/headache
- ☐ Neurological disease
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Shortness of breath
- ☐ Stroke
- ☐ Vision loss
- ☐ Other:

Surgical History

Surgery	Date

Current Medications/Supplements

Name	Reason for taking

Please bring medication list with you if more space is needed

Social History

Are you currently working? ☐ Yes ☐ No

What is /was your profession?

How active do you consider yourself?

☐ Not active ☐ Somewhat ☐ Regularly ☐ Very

List of regular exercise

Hobbies

How often is stress a significant factor in your life?

☐ Never ☐ Seldom ☐ Regularly ☐ Always

Current Condition (What symptoms are you currently experiencing?)

- ☐ Dizziness
- ☐ Nausea/vomiting
- ☐ Motion sickness
- ☐ Double vision
- ☐ Fatigue
- ☐ Headaches
- ☐ Hearing loss
- ☐ Ear pressure
- ☐ Muscle weakness
- ☐ Fever/chills/sweats
- ☐ Weight loss/gain
- ☐ Numbness/tingling
- ☐ Frequent falls
- ☐ Difficulty concentrating
- ☐ Difficulty sleeping
- ☐ Other:

Have you received treatment for your current condition? If so, what treatment? ☐ Yes ☐ No

What is your goal for physical therapy?