



CENTER FOR BALANCE DISORDERS

One Baylor Plaza Houston, Texas 77030
Tel (713) 798-6336 Fax (713) 798-8658

PATIENT INTAKE FORM

The Neurosensory Center of Houston
3rd Floor, Room NA315

ID Number: _____

Test Date: _____

Visit #: _____

Patient Information:						
Name: Last	First	MI	Birthdate: Month	Day	Year	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number:			Age:		
Address: Street		Apt.#		Height:		
City		State		Weight:		
Telephone: Home: ()			Right or Left Handed:			
Cell: ()			Drivers License #:			
Work: ()			e-mail Address:			
Emergency Contact:						
Emergency Contact Name: Last		First		MI		
Emergency Contact Phone: ()			Relationship to Patient:			
Primary Insurance Information:						
Primary Insurance:			Type: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Other			
Name of Subscriber:			Eligibility Phone: ()			
Subscriber ID:			Group #:			
Subscriber Birthdate:			Subscriber SSN:			
Secondary Insurance Information:						
Secondary Insurance:			Type: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Other			
Name of Subscriber:			Eligibility Phone: ()			
Subscriber ID:			Group #:			
Subscriber Birthdate:			Subscriber SSN:			
Patient Consent:						
I hereby authorize Baylor College of Medicine, The Bobby R. Alford Department of Otolaryngology – Head and Neck Surgery, and/or the Center for Balance Disorders, to release any medical records to my insurance company as necessary in order to adjudicate my claims.						
I understand that I am ultimately financially responsible for services rendered by Baylor College of Medicine, The Bobby R. Alford Department of Otolaryngology – Head and Neck Surgery, and/or the Center for Balance Disorders.						
Signed: _____			Date: _____			
(Patient or Other Legally Responsible Person)						

Test Battery: _____ Referring MD: _____ Technician _____