Patient Information

Patient's Name: ______________________________ Date of Birth: _____/_____/_____
Address: ____
City: ____________________________ State: _____________ Zip: ____________
SS#: _____-____-_____ Sex: ______ Race: ________ Marital Status: ____ # of Children: ___
Home Phone: (___)__________ Work Phone: (___)_________ Cell Phone: (___)_________
Email Address: ____
Diagnosis: _________________________ Referring Physician: ____________________

Any Previous HBOT? Y☐ N☐ If yes, give details: ______________________________
____

Any Recent Sinus or Ear Problems? Y☐ N☐ If yes, give details: ____________________
____

Does Patient have seizure disorder? Y☐ N☐ If yes, give details: ____________________
____

Does client have ear tubes? Y☐ N☐ If yes, when were they placed? __________________

Please List Any Current Medications: ____
____

How did you hear about us? ____

Responsible Party

Parent or Guardian's Name(s): ____
Relationship to Patient: ____
Address: (If different than above) ____
City: ____________________________ State: _____________ Zip: ____________
Home Phone: (___)__________ Work Phone: (___)_________ Cell Phone: (___)_________

Emergency Contact

Name: ____
Relationship to Patient: ____
Address: ____
City: ____________________________ State: _____________ Zip: ____________
Home Phone: (___)__________ Work Phone: (___)_________ Cell Phone: (___)_________