Cincinnati HYPERBARICS
A Natural Way to Wellness

PATIENT INFORMATION

PATIENT'S NAME:	**DATE OF BIRTH:**
ADDRESS:	**CITY, STATE, ZIP:**
SOCIAL SECURITY#	**SEX:**
RACE:	**MARITAL STATUS:**
PHONE#	**EMAIL:**
DIAGNOSIS:	**REFERRING PHYSICIAN:**

Any previous HBOT? Yes ☐ No ☐

If yes, give details:_____

_____

Any recent sinus or ear problem? Yes ☐ No ☐

If yes, give details:_____

_____

Does patient have history of seizure activity or disorder? Yes ☐ No ☐

If yes, give details:_____

_____

Does patient have ear tubes? Yes ☐ No ☐ If yes, when were they placed?_____

Please any current medications?_____

_____

How did you hear about Cincinnati Hypberbarics?_____

_____

RESPONSIBLE PARTY

PATIENT OR GUARDIAN'S NAME(S):_____

RELATIONSHIP TO PATIENT:_____

ADDRESS (IF DIFFERENCE FROM ABOVE):_____

CITY:_____ **STATE:**_____ **ZIP:**_____

PHONE NUMBER: _____

EMERGENCY CONTACT

PATIENT OR GUARDIAN'S NAME(S):_____

RELATIONSHIP TO PATIENT:_____

ADDRESS (IF DIFFERENCE FROM ABOVE):_____

CITY:_____ **STATE:**_____ **ZIP:**_____

PHONE NUMBER: _____