

CENTRAL PHYSICAL THERAPY  
13111 HOOPER ROAD  
CITY OF CENTRAL, LA 70818

TEL #: 225-261-7094

HELEN M BALZLI PT  
[www.crcpt.com](http://www.crcpt.com)

FAX: 225-261-7095

Date: \_\_\_\_\_ Patient #: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_ Age \_\_\_\_\_ Sex: \_\_\_\_\_

Phone # \_\_\_\_\_ Cell # \_\_\_\_\_ Marital Status: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Emergency Contact/Guardian \_\_\_\_\_ Phone#: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Referral Source \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Physician \_\_\_\_\_ Friend \_\_\_\_\_ Advertisement \_\_\_\_\_ Other

Are you receiving Physical Therapy as a result of:

Motor Vehicle Accident  Work Related Injury/Accident  Surgery  
 Other

If other, list reason: \_\_\_\_\_

Have you retained or plan to retain an attorney? \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

Have you been under the care of a Home Health Agency for Physical Therapy/Speech

Therapy?  Yes  No

If yes, please list: Name of Home Health Agency: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Name of Therapist: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

If yes, please list, Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

How did you hear about us?  Physician  Friend  Advertisement  Other