

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

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HELEN M BALZLI PT

FAX: 225-261-7095

www.crcpt.com

Patient Name _____ Date _____

Permanent Address _____

City/State/Zip _____ DOB _____

Social Security # _____ Age _____ Sex _____

Phone # _____ Cell # _____ Marital Status _____

Email Address _____

Spouse Name _____ Phone # _____

Emergency Contact/Guardian _____ Phone # _____

Responsible Party _____ Relationship _____

Referral Source _____ Employer _____

Primary Insurance _____ Policy # _____

Secondary Insurance _____ Policy # _____

Are you receiving physical therapy as a result of:

Motor Vehicle Accident ____ Work Related Injury/Accident ____ Surgery ____

If other, list reason: _____

Have you retained or plan to retain an attorney related to your accident/injuries? Y N

If yes, please provide name, telephone number and address of your attorney: _____

Date of Injury _____ Date of Surgery _____

Name of other party involved in accident and name of his/her adjuster _____

If you have been contacted by an insurance adjuster relating to your accident, please provide the following information.

Name of Insurance Company _____

Name of Adjuster _____

Claim Number _____

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 _____

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