PRECISION
PHYSICAL THERAPY & SPORTS MEDICINE

☐ 17134 HWY 44 STE. F
PRAIRIEVILLE, LA 70769

☐ 18539 HWY 22 STE. F
PONCHATOULA, LA 70454

PATIENT INFORMATION

NAME: _____ **DOB:** ____/____/____

MAILING ADDRESS: _____

GENDER: _____ **SSN:** _____ **DL #:** _____

HOME PHONE: _____ **CELL:** _____ **WORK:** _____

EMPLOYER: _____ **PHONE:** _____

EMAIL: _____ **PREFERRED METHOD OF CONTACT:** _____

REFERRING DR: _____ **PHONE:** _____

SPOUSE'S NAME: _____ **DOB:** ____/____/____

EMERGENCY CONTACT

CONTACT NAME: _____

PHONE: _____ **RELATION TO PATIENT:** _____

PAYMENT INFORMATION

WHO IS RESPONSIBLE FOR THIS BILL? NAME: _____

RELATION TO PATIENT: _____ **PHONE:** _____

ADDRESS: _____

IS THIS AN ATTORNEY?: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

GROUP # _____ **POLICY #** _____

CLAIMS ADDRESS: _____

POLICY HOLDER NAME: _____ **DOB:** _____

SECONDARY INSURANCE: _____

GROUP # _____ **POLICY #** _____

CLAIMS ADDRESS: _____

POLICY HOLDER NAME: _____ **DOB:** _____

THERAPY HISTORY

HAVE YOU HAD THERAPY BEFORE? ☐ YES ☐ NO YEAR: _____ **TYPE:** _____

PROVIDER/COMPANY: _____

HAVE YOU HAD HOME HEALTH FOR THE CURRENT INJURY: ☐ YES ☐ NO

IF YES, WHAT WAS THE COMPANY? _____ **DISCHARGE DATE** _____

AUTHORIZATION & SIGNATURE

I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS CLAIMS. I ALSO AUTHORIZE DIRECT PAYMENT OF MY MEDICAL BENEFITS TO PRECISION PHYSICAL THERAPY & SPORTS MEDICINE, LLC AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY NON-COVERED SERVICES.

_____ _____

PATIENT/PARENT OR GUARDIAN SIGNATURE **DATE**

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INJURY AND MEDICAL HISTORY

NAME: _____ **DOB:** ____/____/____

ALLERGIES: _____

DATE OF INJURY OR WHEN SYMPTOMS BEGAN: _____

INJURY WAS INCURRED BY: **DESCRIBE YOUR SYMPTOMS OR PAIN:**

AUTO _____ _____

SCHOOL SPORT _____ _____

WORK _____ _____

OTHER _____ _____

DID YOU HAVE SURGERY FOR THIS CONDITION? _____ **DATE OF SURGERY:** _____

WHAT ACTIVITIES ARE PAINFUL OR DIFFICULT TO DO BECAUSE OF YOUR INJURY:

_____

_____

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOU:

☐ **ASTHMA:** _____

☐ **CANCER:** _____ **TYPE:** _____

☐ **DIABETES INSULIN?** ☐ **YES** ☐ **NO**

☐ **SEIZURES:** _____

☐ **STROKE:** _____

☐ **HIGH BLOOD PRESSURE:** _____

☐ **PACEMAKER:** _____

☐ **DEFIBRILLATOR:** _____

☐ **OTHER:** _____

☐ **PREGNANT:** _____

☐ **OSTEOPOROSIS:** _____

☐ **RHEUMATOID ARTHRITIS:** _____

☐ **SHINGLES:** _____

☐ **HEART DISEASE:** _____

☐ **HEPATITIS:** _____

☐ **INFECTIOUS DISEASE:** _____

☐ **AUTOIMMUNE DISEASE:** _____

☐ **OTHER RECENT SURGERY:** _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

1. _____
2. _____
3. _____
4. _____
5. _____

LIST PREVIOUS SURGERIES & DATES:

_____

_____

_____

_____

_____

_____ _____

PATIENT/PARENT OR GUARDIAN SIGNATURE **DATE**