NELA REHABILITATION
204 Boots Drive Farmerville, LA 71241
Phone: (318) 620 – 0075 Fax: (318) 620 - 0070
www.nelarehab.com

Helping you learn to live beyond your current bounds.

PATIENT INFORMATION – ADULT

Patient Name: _____ Preferred Name: _____

Address: _____ City: _____ State:_____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____ D.O.B. _____ Gender: Male Female

RESPONSIBLE PARTY (If not patient)

Name: _____

Address: _____

_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

D.O.B.: _____

Social Security: _____

Email: _____

Employer: _____

Relationship to Patient: Mother Father Guardian

INSURANCE INFORMATION

Name of Insurance Company: _____

Name of Policy Holder: _____

Policy Holder Address: _____

_____

Home Phone: _____

Work Phone: _____ Cell Phone: _____

D.O.B.: _____ SS#: _____

Employer: _____

Policy Holder ID: _____

Group #: _____

Relationship to Patient: Mother Father Guardian Self

EMERGENCY/ALTERNATE CONTACT NUMBERS

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

How did you hear about us? ☐ Word of Mouth ☐ Physician Reference ☐ Advertizing ☐ Search Engine ☐ Insurance Provider List

Assignment of Insurance Benefits: I hereby authorize Northeast Louisiana Rehabilitation, LLC to provide any medical care that is deemed necessary. I hereby authorize payment of benefits directly to Northeast Louisiana Rehabilitation, LLC. I hereby authorize Northeast Louisiana Rehabilitation, LLC to release any information necessary to process my claim. I acknowledge/understand that I am responsible for any charges incurred that my insurance does not pay for or cover for any reason whatsoever. I also acknowledge that if my account is turned over to a collection agency that I will be responsible for the collection fee towards my account. I also attest that the information that I have provided above is correct and truthful to the best of my knowledge.

Patient/Guardian's Signature: _____ Date: _____

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Medical History Questionnaire

What is your main reason for needing therapy?

_____

When and how did this begin? _____

_____

What imaging (ie. Xray, MRI, CT) have been performed? Include date and results if known.

_____

Are you currently working? _____ YES _____ NO Occupation? _____

In what type of recreational activities do you participate? _____

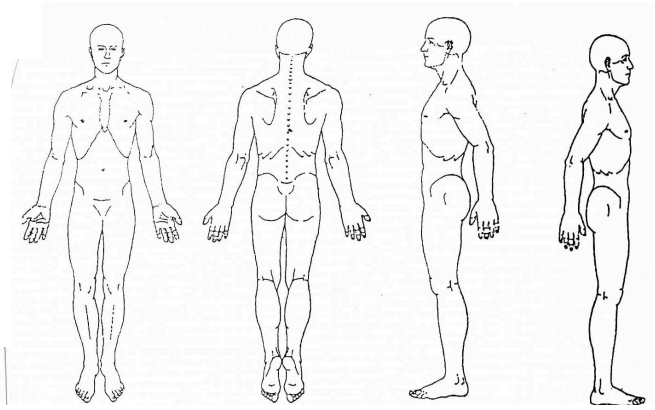
Do you smoke? _____ YES _____ NO

When is your next appointment with referring MD? _____

Any scheduled appointments with other doctors? _____

Primary Care Physician's Name and Clinic: _____

****Please Shade in Specific Areas of Pain on the Diagrams****



Rate your pain on a scale of 0-10 (0 = no pain and 10 = emergency room pain)

____/10 right now

____/10 at its worst

____/10 at its best

Please list all Current Medications, dosages, and frequency (or provide a list to be copied):

Name and Purpose	Dosage	Frequency	Route

Please list all current medical conditions (ie. Diabetes, High Blood Pressure, Heart Conditions, etc.) and all previous surgeries and dates:
