TRUESPORTS PHYSICAL THERAPY

1. Please enter your patient demographics.

Patient First Name: Taylor
Patient Last Name: Jackson
Nickname:
Date of Birth: 3/10/2008 (age 16)
Last 4 digits of SS:
Sex at birth: ☑ Female
Preferred Pronoun:
Street Address: 302 Kirkwood Road
Apt/ Unit #:
City: Millersville
State: MD
Zip Code: 21108
Mobile Phone: (443) 926-1373
Email: KristinPJackson@yahoo.com
Emergency Contact Name: Kristin Jackson
Emergency Contact Telephone Number: (443) 926-1373

2. Please enter your Primary Health Insurance information. As a friendly reminder, this allows our office to verify your insurance coverage and predetermine your financial responsibility. We highly encourage all patients to contact their insurance prior to the initial visit.

Primary Insurance Carrier:

☐ Aetna ☐ Anthem Blue Cross/ BS ☐ BCBS Federal Employee Program ☐ Cigna/ ASH ☑ Carefirst Administrators
☐ Carefirst Blue Choice ☐ Carefirst/ Blue Cross Blue Shield ☐ Medicare - Part B (Referral is required)
☐ Johns Hopkins EHP (Referral is required) ☐ United Healthcare (Referral is recommended) ☐ Self Pay
☐ Tricare/ Humana Miltary (Referral is recommended) ☐ US Family Health Plan - Johns Hopkins Medicine
☐ Workers Compensation Claim (Referral is required)
☐ Motor Vehicle Accident (Secondary Insurance is recommended)

ID# (including any letters and numbers): S4Z000018
Group# (including any letters and numbers): S4Z
Insurance Address (found on back of card):
Insurance Phone # (found on back of card):
Policyholder's Name: Jeffrey Jackson
Policyholder's DOB: 110979
Relationship to Patient: Parent/ Guardian

3. How did you find out about us?

☐ Doctor ☐ Insurance Plan ☑ Friend/ Family Quinones
☐ Google ☐ Facebook ☐ Workers' Compensation
☐ Auto Accident ☐ Coach/ Trainer ☐ Instagram

4. What injury/ body part brings you in today?

Lower back injury

5. How did your injury occur?

☐ Auto Accident ☐ Fall ☑ Sports Injury lacrosse
☐ Employment Injury ☐ Surgery ☐ Personal Injury

6. Please enter your Medical History.

Date of Injury
Nov 2023

Date of Surgery

Referring Physician

How severe is your pain:
7

Have you previously had PT for this injury?
○ Yes ◉ No

Have you experienced any of the following symptoms related to this injury?
☑ Numbness/ tingling

Have you had any special test(s) related to this injury?
☑ MRI ☑ X-ray ☑ CT Scan

Please check if you have or have had any of the following:
☑ None of the above

Do you currently:
☑ Exercise ☑ Drink caffeine

Please list any medications (including vitamins and supplements) that you are currently taking:

7. Please enter your Secondary Health Insurance (if applicable).

Secondary Insurance Carrier:

ID#:

Group #:

Secondary Insurance Address:

Secondary Insurance Phone:

Policyholder's Name (if different)

Policyholder's DOB:

Relationship to Patient:

Is your secondary insurance through a school or sports team? If yes we will need an Incident Report
☐ Yes ☐ No

8. Did you download the True Sports Mobile App? If not please download the app now as you will receive video access to your assigned at home exercises with explanation, repetitions, etc. of how to do each. Link: https://apps.apple.com/us/app/true-sports-mobile/id1539002332

☑ Yes ☐ No

*Signed by Kristin Jackson on Nov 19, 2024 at 03:03 PM from IP 174.196.137.****