

**REID & YATES PHYSICAL THERAPY
ORTHOPEDIC AND SPORTS PHYSICAL THERAPY
COLUMBIA ORTHOPEDIC AND SPORTS PHYSICAL THERAPY**

PATIENT INFORMATION (Please Print)

***DATE OF INJURY/ONSET:** _____

Name: _____

Sex: [] M, [] F Marital Status: [] Married, [] Single, [] Other

Address: _____

Date of Birth: _____

City, State & Zip: _____

Social Security #: _____

Phone: _____ [] Home [] Work [] Other

E-mail Address: _____

Phone: _____ [] Home [] Work [] Other

Referring Physician: _____

Primary Physician: _____

PATIENT'S EMPLOYMENT INFORMATION

EMERGENCY CONTACTS

[] Employed [] Retired [] Student [] Other

Name	Relationship	Phone
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Employer/School: _____

Attorney Involved: Name: _____

Phone: _____

Phone: _____

GUARANTOR INFORMATION [] Same as Patient

Name: _____

Phone: _____

Address: _____

SSN: _____

City, State & Zip: _____

Date of Birth: _____

PRIMARY INSURANCE INFORMATION

SECONDARY INSURANCE INFORMATION

[] Same as Patient [] Same as Guarantor [] Other

[] Same as Patient [] Same as Guarantor [] Other

Insured Party Name: _____

Insured Party Name: _____

Insured Phone: _____

Insured Phone: _____

Insured's Employer: _____

Insured's Employer: _____

Insurance Company: _____

Insurance Company: _____

Insured ID: _____

Insured ID: _____

Social Security #: _____

Social Security #: _____

Insured's Date of Birth: _____

Insured's Date of Birth: _____

Policy/Group #: _____

Policy/Group #: _____

Patient's Relationship to Insured: _____

Patient's Relationship to Insured: _____

Date of Injury/Onset: _____

Date of Injury/Onset: _____

Accident Relating Injury (Work, Auto, Other) **Circle one. Must be completed if injury is related to work or auto accident.**

Insurance Company Name: _____ Claim Number: _____

Address: _____ Phone: _____

City, State & Zip: _____ Employer at time of injury: _____

Date of Injury: _____ Body Part: _____ Claim Adjuster/phone #: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

(Please read and sign)

I hereby authorize Reid and Yates Physical Therapy/OSPT/COSPT to furnish the above names insurance company with any necessary information needed to process the claim. I also authorize said insurance to pay and assign all benefits to Reid and Yates Physical Therapy/OSPT/COSPT for all billings of my physical therapy. The above information is true and correct to the best of my knowledge.

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____ **DATE:** _____