Southern Oregon Physical Therapy Associates, Inc.

924 S. Riverside• Medford, OR 97501 • (541) 773-7678 • Fax: (541) 773-5517

♦Email: sopta@integra.net ♦ website: southernoregonphysicaltherapy.com ♦

PATIENT INFORMATION

Patient Name ____ **Date of Birth** __________________

Last First Middle

Social Security # ________________________ **Sex:** ☐ Male ☐ Female **Marital Status:** ☐ Married ☐ Single ☐ Other

Address ______________________________________**City** ____________________**State**______ **Zip Code** _____________

Home Phone ______________________ **Cell Phone** ________________________ **Work Phone** ______________________

Employer ____ **Occupation** ____

Referring Physician __________________________________ **Family Physician** ____________________________________

Person Responsible for Account if not Patient: SPOUSE, GUARANTOR or CUSTODIAL PARENT

Name ____ Date of Birth __________________

Last First Middle

Social Security # ________________________ Sex: ☐ Male ☐ Female Marital Status: _______________________________

Address ______________________________________City ____________________State______ Zip Code ______________

Home Phone _____________________ Cell Phone _____________________ **Relationship to Patient** ___________________

EMERGENCY CONTACT (Not living with you)

Name ____Relationship to Patient _____________________

Last First Middle

Home Phone ________________________ Cell Phone ________________________ Work Phone ________________________

INSURANCE INFORMATION

If Injured, Date of Injury _____________ **State** _______ ☐ **Auto Accident** ☐ **Work Related** ☐ **Other** _________________

Have you retained an attorney? ☐ No ☐ Yes If Yes, Attorney Name ____

Primary Insurance __________________________________ **Subscriber Name** _____________________________________

Insurance ID/Claim# ______________________________Group # _______________ **Phone**___________________________

We Will Copy Your Insurance Card, BUT if the Subscriber IS NOT the Patient Please Complete the Subscriber Information.

Subscriber Social Security# _____________________________ Subscriber Date of Birth _______________________________

Secondary Insurance ____ **Subscriber Name** ____________________________

Secondary Insurance ID/Claim# ___________________________________ Group # ___________________________________

Subscriber Social Security# _____________________________ Subscriber Date of Birth _______________________________

Note:

We will use your Primary Phone to leave appointment reminders: Primary Number is ☐ Home ☐ Cell ☐ Work

You will receive a reminder call for all appointments. We will identify that you are receiving physical therapy and give date and time of your next appointment. If we are unable to speak to you personally, we will leave a verbal message with whoever answers the phone or leave a voice mail message. **If you prefer an alternative method of communication**, please list here: ___________________________

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

I hereby give authorization for payment of insurance benefits to Southern Oregon Physical Therapy Associates, Inc. for any services rendered. **I understand I am financially responsible for all charges whether or not they are covered by insurance.** I further expressly agree and acknowledge that my signature on this document authorizes this clinic to submit claims for services rendered. I also authorize this healthcare provider to release all information necessary to secure payment of benefits. (If patient is a minor, a parent or guardian must sign this release.)

____ _____________________________________

Patient or Parent/Guardian Signature **Date**

© SOPTA, INC. 3/2016