



proaxistherapy

### New Patient Information Sheet

Please help us serve you better by taking a few minutes to provide the following information.

#### PATIENT INFORMATION

Account #	Social Security #	Title	Last Name	First Name	MI
Street Address (Road or Street)			Email Address:		
Zip Code	City	State	I give Proaxis Therapy permission to contact me via email: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Home Phone:	Cell Phone:	Patient Data: (Nick Name)			
Date of Birth	Sex (M, F)	Referring Doctor (Full Name)			
Marital <input type="checkbox"/> M-Married <input type="checkbox"/> W-Widowed <input type="checkbox"/> S-Single <input type="checkbox"/> D-Divorced <input type="checkbox"/> X-Separated	Student <input type="checkbox"/> P-Part <input type="checkbox"/> F-Full <input type="checkbox"/> N-None	How did you hear about us? <input type="checkbox"/> Family/Friend <input type="checkbox"/> Radio/TV _____ <input type="checkbox"/> Proaxis Website <input type="checkbox"/> Other Website _____ <input type="checkbox"/> Event _____ <input type="checkbox"/> Print Ad _____ <input type="checkbox"/> FURMAN UNITED <input type="checkbox"/> 360studentathlete			
Employer Name	Employment <input type="checkbox"/> R-Retired <input type="checkbox"/> F-Full <input type="checkbox"/> P-Part <input type="checkbox"/> N-None				
Employer Street Address (Road or Street)					
Zip Code	City	State	Business Phone	Ext	

#### INSURANCE INFORMATION

<b>Primary Insurance Company Name</b>	Mailing Address				
Insurance Telephone #	Policy #	Group #	Relationship to Insured <input type="checkbox"/> SE-Self <input type="checkbox"/> SP-Spouse <input type="checkbox"/> OT-Other <input type="checkbox"/> CH-Child		
<b>Secondary Insurance Company Name</b>	Mailing Address				
Secondary Telephone #	Policy #	Group #	Relationship to Insured <input type="checkbox"/> SE-Self <input type="checkbox"/> SP-Spouse <input type="checkbox"/> OT-Other <input type="checkbox"/> CH-Child		

#### COMPLETE IF INSURANCE IS IN SPOUSE'S/PARENT'S NAME

Social Security #	Title	Last Name	First Name	MI
Date of Birth	Sex (M, F)	Relationship to Insured:		

#### ACCIDENT DETAILS

Employment Related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Accident Related? <input type="checkbox"/> Auto <input type="checkbox"/> Other <input type="checkbox"/> No	Date of first symptom or accident:
Give Details of Accident:		

I authorize the release of any medical or other information necessary to process insurance claims.

I authorize payment of medical benefits directly to this practice for the services rendered.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

Front Office Use: \_\_\_\_\_