New Patient Information Form **Please use BLUE or BLACK Ink**

The Physical Therapy Clinic, Inc. **dba Axis Physical Therapy** 26 Office Park Dr. Jacksonville, NC 28546

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

Patient Information

Title	Last Name	First Name	MI	Preferred Name	Social Security #

Street Address	Apartment #	Zip Code	City	State

Mailing Address (or secondary address)	Apartment #	Zip Code	City	State

Cell Phone	Home Phone	Work Phone	Ext	Date of Birth

Sex (M,F)	Referring Doctor	E-mail Address

How did you hear about us? ☐ Doctor ☐ Friend / Family ☐ Google ☐ Facebook ☐ Yellow Pages ☐ Other: _____

Marital	Employment	Student	Relationship to Insured
☐ Married ☐ Widowed	☐ Retired	☐ Part	☐ Self ☐ Spouse
☐ Single ☐ Divorced ☐ Separated	☐ Full ☐ Part ☐ None	☐ Full ☐ None	☐ Other ☐ Child

Employer Name	Employer Address

Sponsor (if other than patient) / Spouse / Parent (if Minor) / or Emergency Contact (if not married)

Social Security #	Title	Last Name, First Name MI	Date of Birth

Sex (M,F)	Relationship	Phone Number	Mailing Address

Accident Details -- Please complete if visit is due to Injury

Employment Related	Accident Related	Date of first symptom or accident
☐ Yes ☐ No	☐ Auto ☐ Other ☐ No	

Give Details of Accident

*****If injury is due to **AUTO ACCIDENT** please complete below and **provide copy of ACCIDENT REPORT***

YOUR Auto Insurance Name	Policy or Claim #	**OTHER PARTY'S Auto Insurance** Name	Policy or Claim #

Attorney's Name	Attorney's Phone #

Medical Insurance Information (provide card so that we may copy)

Primary Insurance Company Name	**Secondary Insurance** Company Name	**Other Insurance** Company Name(s)

Assignment of Benefits/Proceeds: I hereby instruct and direct ALL payers responsible for making payments towards the treatment of my injuries to pay The Physical Therapy Clinic, Inc. dba Axis Physical Therapy 26 Office Park Dr., Jacksonville, NC 28546 for the professional or medical benefits / proceeds allowable, and otherwise payable to me as payment toward the total charges for the professional services rendered. This is a direct assignment of my rights and benefits / proceeds under ANY applicable policies / agreements. I further intend for this Assignment to create a secured interest under the applicable Uniform Commercial Code. **Authorization to Release Information:** I have received and read the HIPAA Notice of Privacy Practices of The Physical Therapy Clinic, Inc. dba Axis Physical Therapy and I authorize the release of any medical or other information necessary to verify benefits / obtain payment, complete treatment, and as described in the Notice. **Consent to Evaluation & Treatment:** I do hereby consent to the evaluation and treatment by The Physical Therapy Clinic, Inc. dba Axis Physical Therapy. I understand it is my right to accept or refuse any treatment offered me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

Signed (Patient and/or parent/legal guardian) Date