Therapy Resource Associates
One Professional Square
10824 Old Mill Road, Suite 21 Omaha, NE 68154-2642
Phone 402.330.6060 Fax 402.330.6108

NEW PATIENT INFORMATION PACKET

We thank you in advance for taking the time to fill out the following as completely as possible.

PATIENT'S INFORMATION

First Name: _____ M.I._____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Marital Status: M____ S____ O____

Home Phone: _____ Work/Cell/Other Phone:_____

Social Security: _____ Birthdate: _____ Sex (M/F) _____

Employed (Y/N) _____ Employer / School: _____

Emergency Contact Name/Address/Number_____

PRIMARY INSURANCE POLICY HOLDER OR RESPONSIBLE PARTY INFORMATION

(The person who is the insurance holder or who the statement is sent to -- if different from above)

First Name: _____ M.I._____ Last Name: _____

Street Address:_____

City: _____ State: _____ Zip Code: _____ Marital Status: M____ S____ O____

Home Phone: _____ Work/Cell/Other Phone:_____

Social Security: _____ Birthdate: _____ Sex (M/F) _____

Employed (Y/N) _____ Employer / School: _____

Please take a few moments to answer the following questions:

- Can you tell us how you first heard of Therapy Resource Associates?
  _____
  _

- Were you referred directly by another doctor, your benefit plan, or an EAP? Please describe.
  _____
  _

- Primary reason for being here: ( ) family ( ) work ( ) depression ( ) alcohol/drug ( ) anxiety ( ) other

_____