

Blue Water Therapy

916 N. Dixie Freeway
New Smyrna Beach, Florida 32168
Phone: 386-426-7885 Fax: 1-866-239-9013
bluewatertherapy1@gmail.com

Patient Registration Form

Patient Information

Date: _____ Home Phone: _____ Cell phone: _____
Name: _____ Soc Sec. No. _____ - _____ - _____
Address: _____ DL# _____
City: _____ State: _____ Zip: _____
Sex: Male Female Age: _____ Date of birth: _____
 Single Married Widowed Separated Divorced

Emergency Contact Information

In case of an emergency who should we contact?

Name: _____ Home Phone: _____ Cell Phone: _____
Relationship to you? _____

Primary Insurance

Insurance Company: _____
Contract# _____ Group#: _____ Subscriber# _____
Person Responsible for Account: _____
Address(If different from patient): _____
City: _____ State: _____ Zip: _____
Relationship to Patient: _____
Birthday: _____ Soc Sec No: _____ - _____ - _____
Person Responsible Employed by: _____ Occupation: _____
Business Address: _____ Business Phone: _____

Additional Insurance

Is the patient covered under additional insurance? YES NO
Insurance Company: _____ Soc Sec No: _____ - _____ - _____
Contract# _____ Group#: _____ Subscriber# _____
Person Responsible for Account: _____
Address(If different from patient): _____
City: _____ State: _____ Zip: _____
Relationship to Patient: _____
Birthday: _____ Soc Sec No: _____ - _____ - _____
Name of other Dependents Covered Under this Policy: _____

Responsible Party Signature

Relationship

Date

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Medical History

Patient Name: _____ D.O.B _____
Name of Physician: _____ Phone # _____

Are you in good health? Yes No

In the last five years have you been: (if yes, please explain)

- a. Hospitalized? No Yes _____
b. Had a serious illness? No Yes _____
c. Had a major operation? No Yes _____

Please check the following that pertain to you:

- | | |
|---|---|
| <input type="checkbox"/> Heart Surgery, Disease or Attack | <input type="checkbox"/> Surgery/Treatment Tumor/Growth |
| <input type="checkbox"/> Angina Pectoris/Chest Pain | <input type="checkbox"/> AIDS or HIV positive |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hepatitis, Jaundice or Liver Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Rheumatic Fever/Heart Disease | <input type="checkbox"/> Drug Addiction/Alcoholism |
| <input type="checkbox"/> Heart Murmur/MVP | <input type="checkbox"/> Hemophilia or Excessive Bleeding |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Psychiatric/Mental Disorders |
| <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Knee Replacement |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Cancer or Tumors | <input type="checkbox"/> Sinus Trouble (Sinusitis) |
|
 | |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Lung Disease/Tuberculosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> | |

Other: _____

Please list all allergies or unusual reactions that pertain to you:

Patient Signature _____ Date: _____

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Medical Records Release and Request Form

I (the undersigned) give my consent for Blue Water Therapy to request and receive any and all medical documents related to my treatment of physical therapy performed through them. I also hereby authorize Blue Water Therapy to release medical information necessary to any and all parties involved in my medical treatment (example: health care providers, insurance carriers, attorney or any other person representing me on my behalf).

Patient Signature or Guardian Date

Print Name or Guardian Date

Date of Birth

Treating Physician

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Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, auto or any other health/medical plan, to issue payment check(s) directly to BLUE WATER THERAPY INC., for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize BLUE WATER THERAPY INC., to (1) release any information necessary to insurance carriers regarding my treatments and condition; (2) process insurance claims generated in the course of examination of treatment; (3) allow a photocopy of my signature to be used to process insurance claims for the period lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from BLUE WATER THERAPY INC. on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges not covered by insurance if any incurred in the course of the treatment.

I further understand that fees are due and payable on the date that the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature Date

Witness Date

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Medication List

<u>Medication</u>	<u>Dosage</u>	<u>Route</u>	<u>Frequency</u>	<u>Start Date</u>

_____ I am on no medications at this time. **(Please check if on no medications)**

Other: _____

Patient Name: _____ Date: _____