

Blue Water Therapy

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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

