

PATIENT REGISTRATION

OCEAN THERAPY CENTER, INC.
(Please Print)

PATIENT INFORMATION					
Last Name:	First:	MI:	Birth Date: / /	Age:	Sex:
Primary Address:		City:	State:	Zip:	
Secondary Address:		City:	State:	Zip:	
Phone:			Cell:		
Email:			Social Security Number:		
Occupation/Work Status:	Employer:	Employer Address:	Employer Phone:		
Primary Care Physician:	Phone#	Referring Physician:	Phone#		

EMERGENCY CONTACT	
Name of Local Friend/Relative:	Relationship to Patient:
Phone:	Cell :

INSURANCE INFORMATION				
Primary Insurance:		ID#	Group#	
Policy Holder (If other than patient):		Relationship:	Date of Birth	SS #
Secondary Insurance:		ID#	Group#	

REASON FOR TODAY'S VISIT	
Please Describe Injury/Accident/Illness:	Date of Onset:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Ocean Therapy Center, Inc. I understand that I am financially responsible for any balance. I also authorize Ocean Therapy Center, Inc. or insurance company to release any information required to process my claims.	
Patient/Guardian Signature:	Date: