



PETER B. LEWIS AQUATIC & THERAPY CENTER CLIENT INFORMATION

DEMOGRAPHICS:

Name: _____ Date: _____
Address: _____ Birth date: _____
City, ST, Zip: _____ Sex: M F
Telephone: (____) _____ Work Telephone: (____) _____
Social Security Number _____
E-mail _____

***DATE OF PRESCRIPTION:

ARE YOU CURRENTLY RECEIVING:	HOME HEALTH SERVICES	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	HOSPICE SERVICES	<input type="checkbox"/> YES	<input type="checkbox"/> NO

REFERRING PHYSICIAN:

Name: _____
Telephone #: _____
Last Physician Visit: _____

PRIMARY PHYSICIAN:

Name: _____
Telephone #: _____
Last Physician Visit: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____
Address: _____
City, ST, Zip: _____ Telephone #: _____

PRIMARY INFORMATION:

Insurance Company: _____ Relation to Insured: _____
Address: _____ ID #: _____

Group #: _____

Telephone #: _____

SECONDARY BILLING INFORMATION:

Insurance Company: _____ Relation to Insured: _____
Address: _____ ID #: _____

Group #: _____

Telephone #: _____