

PETER B. LEWIS AQUATIC & THERAPY CENTER

CLIENT INFORMATION

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

How did you hear about us? _____

Please check all that apply:

Have you seen/heard us on: TV Radio Newspaper Internet

Did a friend refer you? Yes, please thank my friend: _____

Have you had therapy at our facility before? Yes, I returned because: _____

*****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 #: _____

E-Mail _____

PRIMARY BILLING INFORMATION:

Insurance Company: _____ Relation to Insured: _____

Address: _____ ID #: _____

_____ Group #: _____

_____ Telephone #: _____

SECONDARY BILLING INFORMATION:

Insurance Company: _____ Relation to Insured: _____

Address: _____ ID #: _____

_____ Group #: _____

_____ Telephone #: _____

I verify that the above information is valid.

Client Signature

Date