PETER B. LEWIS AQUATIC & THERAPY CENTER OF MENORAH PARK
CLIENT INFORMATION

Name: _____ Social Security Number _____

Address: _____ Birth date _____

Sex: ☐ M ☐ F

City, ST, Zip: _____

Telephone #1: _____ Can Messages be left at this number? ☐ YES ☐ NO

Would you like to receive appointment reminders by:

Phone # 2: _____ ☐ E-mail ☐ Text message *(standard messaging rates apply)*

☐ Phone call *(this grants us permission to leave messages)*

Phone #3: _____

Your therapist needs to know: Ht:_____

E-mail_____

Wt: _____

How did you hear about us? _____

Please check all that apply:

Have you seen/heard us on? ☐ TV ☐ Radio ☐ Newspaper ☐ Internet ☐ Friend

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

ARE YOU CURRENTLY RECEIVING:	HOME HEALTH SERVICES ☐ YES ☐ NO
	HOSPICE SERVICES ☐ YES ☐ NO

REFERRING PHYSICIAN:

Name: _____

Telephone #: _____

PRIMARY PHYSICIAN:

Name: _____

Telephone #: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Phone #1:_____ Phone #2: _____

PRIMARY BILLING INFORMATION:

Insurance Company: _____ Relation to Insured: _____

ID#_____ Group#_____

SECONDARY BILLING INFORMATION:

Insurance Company: _____ Relation to Insured: _____

ID#_____ Group#_____

I verify that the above information is valid.

_____ _____

Client Signature Date

_____ _____

Client Signature Date

_____ _____

Client Signature Date

For office staff only: Initial & Date

_____ _____

_____ _____

_____ _____