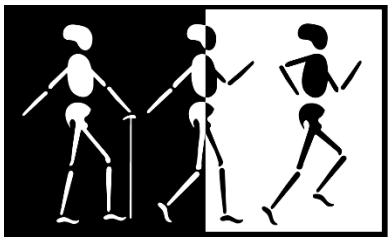
Advance Physical &



Aquatic Therapy

NAME:_____ DOB:_____

ADDRESS:_____ SS#_____

CITY, STATE, ZIP:_____

HOME #_____ CELL:_____ WORK:_____

FAMILY PHYSICIAN:_____

REFERRING PHYSICIAN:_____

PRIMARY INSURANCE: (Office will need to copy all insurance cards)

INS. CO._____ ID#_____

POLICY HOLDER:_____ GROUP#_____

EMPLOYER:_____ BIRTHDATE:_____

SECONDARY INSURANCE:

INS. CO._____ ID#_____

POLICY HOLDER:_____ GROUP #_____

EMPLOYER:_____ BIRTHDATE:_____

EMERGENCY CONTACT:_____

RELATIONSHIP:_____ PHONE #_____

The information I have provided is true and accurate to the best of my knowledge. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNATURE:_____ DATE:_____

965 Baltimore Pike Springfield PA 19064
(P) 610-544-8500 (F) 610-544-8501