FREEDOM REHAB
AQUATIC THERAPY AND BALANCE CENTER

Name: ____

Date of Birth ____

Social Security Number: ____

Address: ____

____
(city) (state) (zip code)

Phone:____

Email:____

Emergency Contact:____

Emergency Contact Phone:____

Physician Name:____

Physician Phone:____

Insurance:

Primary ID:_____________________________________

Secondary ID:___________________________________

Program:

______ Aquatic

______ Freedom from Falls

______ Outpatient on Wheels