INTEGRATIVE HEALTH & WELLNESS
LEWISTON FAMILY CHIROPRACTIC, LLC

Kurt A. Bailey DC, ND, NP-C
Justin Keller DC, DAT

CONFIDENTIAL PATIENT INFORMATION

Name (First/M.I./Last): _____

What would you preferred to be called? _____

Cell Phone: _____ Home Phone: _____

SS #: _____ Work Phone: _____

Address: _____

E-Mail: _____ _____

Age: _____ Birth Date: _____ / _____ / _____ Male_____ Female_____

Marital Status: ____ Single ____ Married ____ Widowed ____ Divorced # of Children: _____

Occupation: _____

Employer: _____

Spouse Name: _____

Spouse Contact Phone: _____

Spouse Occupation / Employer: _____

Emergency Contact: _____ Phone: _____

Have you ever filed for Bankruptcy or Medical Malpractice? _____ Yes _____ No When _____

How did you hear about our clinic? _____

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and the patient. Although Dr. Bailey's office will help me bill, I acknowledge that ultimate payment is my responsibility.

Payment or insurance co-payment is expected at the time of service. I authorize the release of any medical or other information necessary to process claims.

Patient Signature: _____ Date: _____

Guardian/Spouse Signature Authorizing Care: _____

PAYMENT IS EXPECTED AT THE TIME OF SERVICE