INTEGRATIVE HEALTH
LEWISTON FAMILY CHIROPRACTIC, LLC

CONFIDENTIAL PATIENT INFORMATION

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

What would you preferred to be called? _____

Cell Phone: _____ Cell Phone Carrier: _____

Work Phone: _____ May we send you text reminders: ____YES ____NO

Home Phone: _____ SS #: _____

Address: _____

E-Mail: _____

Age: _____ Birth Date: _____ / _____ / _____ (Circle one): Male / Female

Marital Status (Circle): Single / Married / Widowed / Divorced # of Children: _____

Race (Circle): White / American Indian or Alaska Native / Black or African American / Other

Ethnicity (Circle): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Occupation: _____

Employer: _____

Spouse Name: _____

Spouse Occupation/Employer: _____

Spouse Home/Cell/Work Phone: _____

Emergency Contact: _____Phone: _____

Have you ever filed for Bankruptcy or Medical Malpractice (circle): Yes / No When: _____

How did you hear about our clinic? _____

At this time I choose to decline receipt of my clinical summary after EVERY visit – I will request a clinical summary when necessary.

Patient Signature: _____ Date: _____

Guardian/ Parent/ Spouse Signature Authorizing Care: _____

PAYMENT IS EXPECTED AT THE TIME OF SERVICE