

CHRISTOPHER LEPISTO

DOCTOR OF NATUROPATHIC MEDICINE

102 N 4th, Suite 106
Grand Junction, CO 81501
970.250.4104
Fax 866.814.7594
www.grandjunctionnaturopath.com
drchristopher@mac.com

CONFIDENTIAL PATIENT INFORMATION

Please fill in all portions of this form. If you need help, please ask.

Date: _____

Name: _____ DOB: _____ Marital Status: _____

Name of Parent (if minor): _____ City _____ State _____ Zip _____

Current Address: _____ City _____ State _____ Zip _____

Phone: (permanent) _____ (work) _____ (temporary) _____

Sex: _____ email: _____

Occupation _____ Employed by: _____

Work Address _____ City _____ State _____ Zip _____

Name of nearest relative not living with you: _____ Phone: _____

Name of Spouse (or parent for minor child) _____ SS#: _____

Occupation _____ Employed by _____ Phone _____

Whom may we contact in case of emergency? _____ Work # _____

CLINIC POLICY REQUIRES PAYMENT AT TIME OF SERVICES. I WILL BE PAYING MY INITIAL VISITS WITH:

Cash _____ Check _____ Credit Card _____

At time of payment, you will be given an invoice from my office. This will show the diagnosis, services, and charges for that day. If you have coverage you can submit this form directly to your insurance company for reimbursement. The following insurance information will assist our office in dealing with any possible follow up inquiries from your insurance company regarding your claims.

Do you have insurance? Yes _____ No _____

Insurance Company _____ Phone: _____

Name of Primary Insured _____ Relationship to Patient _____

SS# _____ Policy# _____

Secondary Insurance Company _____ Phone: _____

Name of Primary Insured _____ Relationship to Patient _____

SS# _____ Policy# _____