Barneveld Family Chiropractic

New Patient Information Form

Date: _____

Last Name: _____

First Name: _____ Mid Init:_____

Address: _____City:_____State:_____Zip:_____

Home Ph:_____ Cell Ph: _____ Birth Date:_____

Marital Status: M S D W Social Security Number: _____-_____-_____

Email Address: _____

Employer/School Name: _____

Employment Status: (Please Circle)

Full-time Part-time Self Employed Unemployed Retired Active Military

If you have insurance coverage, please provide your insurance card. If you do <u>not</u> have insurance, payment is due at the time of the service, refer to Consent for Use form for details. If your spouse is the primary subscriber for the insurance please provide their date of birth for billing purposes.

Primary Insurance Holder: Name:_____ DOB:_____

<u>Appointment Reminders:</u>

□Opt out of E-mail messages
□Opt out of Text messages
(Automatically opted in)

<u>Online Payments:</u>

□Opt into E-mail messages
□Opt into Text messages
(Automatically opted out)

<u>Emergency Contact:</u>

Name: _____ Relationship:_____

Phone #: _____

Please check all the reasons you selected us for your care: Which is the primary reason? #____

1. Previous BFC Patient__
2. Location__
3.Insurance Handbook__
4.Google/Internet__
5. Newspaper__
6. Mailing__
7. BFC Website__
8. Reputation of Clinic__
9.Referred by family/friend(name)_____
10. Phone Book/ Yellow Pages____
11. Radio/ Media____
12. Other _____