New Patient Basic Information

Date: ______________________

Full Legal Name: ____ Gender: ◯Female ◯Male

What name do you prefer to be called? ____________________________________ Age: _____ Birthdate: _____________________

Occupation: _______________________________________ Employer: ____

Ethnicity: ______________________ Social Security#: ______-_____-________ Marital Status: _______________ # of Children ____

Name of Spouse/Partner or Parent/Guardian: ____

Street Address: ____ City: _________________________ St: ___ Zip: __________

Phone: Home: (_____) _____________ Work: (_____) _____________ Cell: (_____) _____________ Can we text you? ◯Yes ◯No

Best time and way to contact? ____

Email: ____

Whom should we contact in case of emergency? ____Relationship: ______________

Street Address: ____ City: _________________________ St: ___ Zip: __________

Phone: Home: (_____) _____________ Work: (_____) _____________ Cell: (_____) _____________ Is this visit due to a **recent** accident? ◯Yes ◯No. Type: ◯Auto ◯Work ◯Other: ____ How did you find out about the Blair Chiropractic Clinic? ____ Do you have health insurance? ◯Yes ◯No. Company(ies): ____

Full name of Policy Holder: ____ Birthdate: _____________________

Is this through the Policy Holder's work? ◯Yes ◯No. If yes: Employer: ____

Other than Medicare and Medicare supplements, we do not collect payment from health insurance companies. However, we can send electronic receipts so that they may possibly reimburse you under their guidelines. Would you like us to do this? ◯Yes ◯No.

Do you have a primary physician? ◯Yes ◯No. Name: ____

Street Address: ____ City: _________________________ St: ___ Zip: __________

Should you qualify and start care here, shall we send your physician a report? ◯Yes ◯No.

The above information is true and correct to the best of my ability:

Signature: ____ Date: _____________________