

Family Wellness Plan Application

Person filling out form (Primary Member)

First Name: _____ MI: _____ Last Name: _____

Preferred Name or Nickname: _____ Sex: M F Age: _____

Family Information

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Date of Birth: _____

Email Address: _____

How did you find out about our office? _____

Plans – Please choose a plan below which best suits your needs

Basic Plan: Monthly - \$29.99/month 6 Month – One time charge of \$165 Yearly – One time charge of \$300

Gold Plan: Monthly - \$59.99/month 6 Month – One time charge of \$345 Yearly – One time charge of \$650

Platinum Plan: Monthly - \$79.99/month 6 Month – One time charge of \$465 Yearly – One time charge of \$900

Members – Include only members of your immediate family currently residing with you. Please DO NOT list yourself.

1. First Name: _____ MI: _____ Last Name: _____

Preferred Name or Nickname: _____ Sex: M F Age: _____

Relationship to primary member: _____

2. First Name: _____ MI: _____ Last Name: _____

Preferred Name or Nickname: _____ Sex: M F Age: _____

Relationship to primary member: _____

3. First Name: _____ MI: _____ Last Name: _____

Preferred Name or Nickname: _____ Sex: M F Age: _____

Relationship to primary member: _____

Rates increase for families with more than four members. If you need to add additional members, please list them in the space provided on the back of this form and notify us so that we may discuss special pricing.

Additional Members

4. First Name: _____ MI: _____ Last Name: _____

Preferred Name or Nickname: _____ Sex: M F Age: _____

Relationship to primary member: _____

5. First Name: _____ MI: _____ Last Name: _____

Preferred Name or Nickname: _____ Sex: M F Age: _____

Relationship to primary member: _____

6. First Name: _____ MI: _____ Last Name: _____

Preferred Name or Nickname: _____ Sex: M F Age: _____

Relationship to primary member: _____

7. First Name: _____ MI: _____ Last Name: _____

Preferred Name or Nickname: _____ Sex: M F Age: _____

Relationship to primary member: _____

8. First Name: _____ MI: _____ Last Name: _____

Preferred Name or Nickname: _____ Sex: M F Age: _____

Relationship to primary member: _____

9. First Name: _____ MI: _____ Last Name: _____

Preferred Name or Nickname: _____ Sex: M F Age: _____

Relationship to primary member: _____

By my signature below, I hereby attest that the above information is current and accurate. I agree to adhere to the rules and conditions in accordance of the plan I have chosen. I understand that I may discontinue this service at any time by informing a representative of Beistline Chiropractic of my wishes.

X _____ Date: _____