



Name: _____

Date: _____

As a new patient in our office we want your experience to be the best it can be.
Please let us know if you have any questions.

REGULAR FEES:

- New Patient Examination.....\$100 - \$150
- Adjustment.....\$50
- Soft Tissue work (Graston Technique®, and Therapeutic Exercises)\$45

We treat each patient on an individual basis and offer care plans based on your needs.
The Doctor will be happy to go over which fees will be applicable for you today.

PHASES OF CHIROPRACTIC CARE:

- Initial intensive care: Adjustments 2-3 times per week until symptom free.
- Corrective healing: Adjustments 1 time per week without re-lapse of symptoms.
- Wellness: Regular adjustment based on individual patient needs.

PAYMENT OPTIONS:

Insurance:

If you have health insurance of any kind, as a courtesy to you we can verify if there is coverage for Chiropractic care and what patient co-payments / co-insurance apply.

Health Insurance Company (example: Blue Cross, Harvard Pilgrim)

With your approval and signature below, **Duxbury Wellness Center** will bill your insurance and payment will be made directly to our office.

Patient Payment:

If you do not have health insurance, we are happy to let you know about our special Care Savings Plans, which will make it affordable for you to receive Chiropractic care.

Signature: _____

Date: _____



Name: _____

Date: _____

Last Name:		Marital status:	
First Name:	Middle:	Single / Mar / Div / Sep / Widow	
Email:		Birth Date:	Age:
Address:		City:	State:
ZIP Code:	Cell Phone:	Home Phone:	
Occupation:	Employer:		
Medical Care Information			
Do You Have a Family Doctor?: <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Doctor: _____			
Address:		City:	State: ZIP Code:
Date of last Visit: / /		Date of last exam: / /	
Have you had surgery <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, list date and reason for surgery: _____			
Present Illness /Conditions:			
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Prostate trouble
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Sinus trouble
Other:		Medications:	
Family History of Illness:			
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease
<input type="checkbox"/> Allergies	<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Mental/ Emotional Difficulty
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Prostate trouble
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever
Type of Cancer: <input type="checkbox"/> Breast <input type="checkbox"/> Lung <input type="checkbox"/> Other: _____			
Alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per week?	Cigarettes? <input type="checkbox"/> No <input type="checkbox"/> Yes Packs per day?	Caffeine? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per day?	Exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes Hours per week? (circle one) Light / Moderate / Strenuous

How did you hear about us? _____

Signature: _____

Date: _____

