Dr. Robert Blaich
Dr. Shane Wells
Doctors of Chiropractic
425 S. Cherry St., Ste. 903
Denver, CO 80246
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ADMISSION AND PERSONAL DATA

NAME: DATE:

HOME PHONE:

CELL PHONE:

BUSINESS PHONE:

HOME ADDRESS:

CITY: STATE: ZIP:

E MAIL ADDRESS: ____

AGE: BIRTHDATE:

OCCUPATION:

MARITAL STATUS: S M W D

NAME OF SPOUSE: AGES OF CHILDREN:

SPOUSE'S OCCUPATION:

REFERRED TO OUR OFFICE BY:

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE?
IF SO, NAME OF DOCTOR:

PLEASE DESCRIBE THE MAJOR CONCERN(S) THAT BRINGS YOU TO OUR OFFICE:

IF INJURED, PLEASE STATE THE DATE OF INJURY:

- PAYMENT IS DUE AT TIME SERVICES RENDERED (including treatments, nutritional supplements and supports)
- WE DO NOT DIRECTLY BILL INSURANCE COMPANIES.
- YOU WILL BE BILLED FOR ½ OF YOUR VISIT FOR MISSED OR CANCELLED APPOINTMENTS LESS THAN 24 HOURS NOTICE.

PATIENT'S SIGNATURE: ____