425 S. Cherry St, Ste 903
Denver, CO 80246
(303) 399-5117

MILLER CHIROPRACTIC
AND WELLNESS

Personal Intake Form

NAME: DATE:

HOME PHONE:

CELL PHONE:

HOME ADDRESS:

CITY: STATE: ZIP:

E MAIL ADDRESS: _____

AGE: BIRTHDATE:

OCCUPATION:

MARITAL STATUS: S M W D

NAME OF SPOUSE: AGES OF CHILDREN:

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: _____