



# SYNERGY

HEALTH PARTNERS

14111 E. Alameda Avenue, Suite 200  
Aurora, CO 80012  
(303) 343-1357  
Fax (303) 343-3036

## SIGN- IN SHEET

1250 S. Sheridan Blvd.  
Denver, CO 80232  
(303)-927-7119  
Fax(303)-568-9331

8515 Pearl Street, Suite 100  
Thornton, CO 80229  
(303) 630-0400  
Fax (303) 630-0405

PROVIDER: SYNERGY CHIROPRACTIC CLINIC, PC.

PATIENT NAME:

Angel, Theodore (Jimmy)

By my signature, I acknowledge that I received chiropractic evaluation and/or treatment at this facility on the dates listed below.

- 1) Date 3/1/23 Patient Signature [Signature]
- 2) Date 3/24/23 Patient Signature [Signature]
- 3) Date 3/31/23 Patient Signature [Signature]
- 4) Date 4/1/23 Patient Signature [Signature]
- 5) Date 4/21/23 Patient Signature [Signature]
- 6) Date 4/28/23 Patient Signature [Signature]
- 7) Date 5-5-23 Patient Signature [Signature]
- 8) Date 6-19-23 Patient Signature [Signature]
- 9) Date 6-9-23 Patient Signature [Signature]
- 10) Date 7-6-23 Patient Signature [Signature]
- 11) Date 8-11-23 Patient Signature [Signature]
- 12) Date \_\_\_\_\_ Patient Signature \_\_\_\_\_
- 13) Date \_\_\_\_\_ Patient Signature \_\_\_\_\_
- 14) Date \_\_\_\_\_ Patient Signature \_\_\_\_\_
- 15) Date \_\_\_\_\_ Patient Signature \_\_\_\_\_
- 16) Date \_\_\_\_\_ Patient Signature \_\_\_\_\_
- 17) Date \_\_\_\_\_ Patient Signature \_\_\_\_\_
- 18) Date \_\_\_\_\_ Patient Signature \_\_\_\_\_
- 19) Date \_\_\_\_\_ Patient Signature \_\_\_\_\_
- 20) Date \_\_\_\_\_ Patient Signature \_\_\_\_\_
- 21) Date \_\_\_\_\_ Patient Signature \_\_\_\_\_
- 22) Date \_\_\_\_\_ Patient Signature \_\_\_\_\_
- 23) Date \_\_\_\_\_ Patient Signature \_\_\_\_\_