Dr. Rebecca Vessels

Rock Springs Chiropractic Healing Center

215 Winston Drive
Rock Springs, WY 82901

Phone: (307) 382-3090
Fax: (307) 362-1024

DATE:_____

PATIENTS NAME_____**BIRTHDATE**:_____/____/____ **AGE**:____**GENDER**____

ADDRESS:_____**CITY**_____**ST**_____**ZIP**_____

MAILING ADDRESS (IF DIFFERENT)_____

PHONE: ☐ **CELL** ☐**HOME** _____

EMPLOYER:_____ **SSN** _____-_____-_____

SPOUSE / PARENT / RESP PARTY_____

MARITAL STATUS (CIRCLE): **SINGLE** **MARRIED** **MINOR**

INSURANCE

PLEASE FILL IN ALL INFORMATION, INSURANCE BILLING IS PROVIDED FOR OUR PATIENTS AS A COURTESY. PLEASE BE PREPARED TO PROVIDE INSURANCE CARDS.

INSURANCE COMPANY NAME (PRIMARY):_____

EMPLOYER: _____

NAME OF INSURED _____ **INSURED'S DOB**: _____

INSURANCE COMPANY NAME (SECONDARY):_____

EMPLOYER: _____

NAME OF INSURED _____ **INSURED'S DOB**: _____

HAVE YOU SEEN A CHIROPRACTOR PREVIOUSLY _____ **IF SO, WHEN?**_____

WHO REFERRED YOU TO OUR OFFICE?_____

Our personal concern: our professional and personal concern is just two things, your health and our reputation. Therefore, we accept only those patients whom we sincerely believe we can help. Fees payable when service is received, unless special arrangements have been made.