Essence of Health LLC
1412 NE 134th St. STE 260 Vancouver WA 98685
360-574-3668

Welcome to our Clinic. Please take a few moments to fill out this questionnaire. Thank you.

Patient Name: ______________________________________ How did you hear about us? _________
Street Address: _____________________________________ City, State, Zip: ____________________________
Phone # Home: _____________________________________ Cell/Work: _________________________________
Is it ok to contact you at both numbers listed above? Yes or No Best number to call ___________________________
May we leave a message at this number regarding appointments or questions about your care? Yes ____ No ____
Email address: _____________________________________ Social Security #______________________________
Date of Birth: _____________________________ Gender: Male ______ Female _____
Marital status: _____________________________ Employer Name_______________________________
Occupation: _______________________________

Personal Physician Information

Primary Care Provider :_______________________________ Phone: ____________________________________
Clinic Name :_____________________________________ Clinic address :______________________________
Referring Provider Name: _____________________________ Specialty (if applicable) __________________________
Clinic Name: _______________________________________ Phone: ________________________

Insurance Information

Primary insurance company: ____________________________ ID #_____________________________________
Group # or plan name _________________________________ Phone: ___________________________________
Employee Name: ____________________________________ Date of Birth: ______________________________
Employer's Name: ___________________________________ Relationship to patient: Self Spouse Partner Child

Secondary insurance company: __________________________ ID # _____________________________________
Group # or plan name _________________________________ Phone: ___________________________________
Employee Name: ____________________________________ Date of Birth: ______________________________
Employer's Name: ___________________________________ Relationship to patient: Self Spouse Partner Child

*Is this condition related to: Employment: Yes or No Auto Accident: Yes or No Claim#: ______________
Contact person or claims adjuster/manager :____
If yes to either please enter the date of injury and the state where occurred _________________________________

Assignment of Benefits

My signature below authorizes and directs payment of medical benefits for services billed to my health care provider.

Release of Medical Records

My signature below authorizes the release of my medical records including intake forms, chart notes, reports, and billing statements to my attorneys, health care providers, and insurance case managers, for the purpose of processing my claims. I will inform my therapist immediately upon signing any exclusive Release of Medical Records with my attorney.

Patient Signature: ____ Date: ____________________________
Name if signing for minor: ____ Relationship: _____________________