DOUGLAS W. BENJAMIN, M.S., LMHC
Licensed Mental Health Counselor
Medical Psychotherapy, Counseling & Consultation
PO Box 28262
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Tel. (360) 671-8330
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Patient Information

Personal Information

Name *(last, first, middle int.)*:_____ Birth Date:_____
Address:_____ Phone:_____
_____ Email: _____

Employer/School_____ Marital Status:_____
Referred By:_____ Spouse Name:_____
Emergency Contact *(name/phone/relationship):* _____

Medical Information

Family Doctor_____ Date Last Seen_____

Major Medical Problems	Allergies
_____	_____
_____	_____

Current Medications/Dose _____
_____
_____

Insurance Information

Plan Name _____ Phone _____
Address _____ ID No._____
_____ (or Soc. Sec. #)
_____ Group No._____
Primary Insured (if other than self)_____ Birth Date:_____
Employer_____ Phone _____

Consent

In signing I acknowledge receipt of all information required by Washington State law (RCW 18.9.060) and consent to treatment. I further authorize payment of my health insurance medical benefits to the undersigned provider and authorize the release of any medical or other information necessary to process a health insurance claim.

_____	_____
Patient or Authorized Person/Date	Douglas W. Benjamin, M.S., LMHC/Date