Serenity Wellness Clinic, LLC
8555 SW Tualatin Road, Suite B
Tualatin, Oregon, US - 97062

Transfer Demographics and Insurance

This paperwork is intended for patients who I have seen previously at True Health Medicine from 2018-2020. If you were seen at True Health Medicine prior to 2018, you will need to complete the full new patient paperwork.

If you are a new patient or haven't been seen in 2018-2020, please call or text me at 503-987-3622 to ensure I can send you the correct paperwork.

Thank you for signing up for the Charm patient portal. This allows us to communicate securely and for you to complete paperwork online. Please review and complete this questionnaire to ensure I have updated demographics and insurance information. You should also have received a new consent form. Completing both of these questionnaires is required prior to me delivering any care to you in 2021. If you have any questions, please feel free to message me through the portal or call me at 503-987-3622.

Personal Details

First Name * ____________________

Last Name * ____________________

Date of Birth * ____________________

Gender ☐ Male ☐ Female ☐ Unknown

Blood Group ____________________

Language ____________________

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Unemployed ☐ Retired

Marital Status ☐ Single ☐ Married ☐ Others

Smoking Status ☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never Smoker ☐ Smoker ☐ current status unknown ☐ Unknown if ever smoked

Primary Contact Details

Caregiver First Name ____________________

Caregiver Last Name ____________________

Email * ______________________

Home Phone ______________________

Mobile Phone ______________________

Work Phone ______________________

Fax ______________________

Primary Phone * ☐ Mobile Phone ☐ Home Phone ☐ Work Phone

Address Line1 * ______________________

Address Line2 ______________________

City * ______________________

Country * ______________________

State * ______________________

Zip code * ______________________

Postbox No ______________________

Emergency Contact Name ______________________

Emergency Contact Number ______________________

Extn ______________________

Insurance Information

I bill insurance and am in network with most major insurance carriers. If you have any questions about which insurance companies I work with, please visit my website and review doctorbijana.com/insurance-information/ and/or call your insurance company for details. There is a form linked on the above referenced webpage which can guide you in what to ask your insurance company.

Will be billing insurance for your visits in 2021? * ☐ Yes ☐ No

Insurance Company: ______________________

Who is the primary insured (member)? ______________________

If you are not the primary insured, what is the date of birth of the primary insured? (For example, your parent or spouse) ______________________

Insurance ID:

Insurance Group Number:

What is the address on the back of the card to which bills should be sent?

Please provide the phone number on the back of the card. If there are multiple phone numbers, please list the number which is indicated for providers, claims or billing.

Thank you. Filling this out completely helps me to properly bill your insurance company. If you have a physical card, please bring it to your in-person visit(s). If you are not having an in-person visit, you can send a photo or scan of your insurance card by attaching it to me in a portal message. This also works for cards which are sent to you electronically.

Signature

My signature below attests that the information provided is complete and accurate.

PATIENT SIGNATURE *

DATE: