

ADULT REGISTRATION / UPDATE FORM
GATEWAY ASTHMA & ALLERGY RELIEF / ESSE HEALTH

PATIENT INFORMATION

Patient's Last Name _____ First Name _____ Middle Initial _____ Male Female

Date of Birth _____ Age _____ Social Security # _____ Married Single Divorced Separated Widowed

Ethnicity: Hispanic or Latino Not Hispanic or Latino Decline to Disclose

Race: Asian American Indian or Alaskan Native Black/African American Native Hawaiian/other Pacific Islander White More than one race Other race
 Decline to Disclose

Preferred Language: English Spanish Bosnian Russian Italian French German Chinese Japanese Korean Vietnamese Hindi Polish Thai
 Other

Home Address _____ City _____ State _____ Zip code _____

Phone numbers: Home (_____) _____ Cell (_____) _____ Work (_____) _____ ext _____

E-mail address _____ Occupation _____ Employer name _____

Employer address _____ City _____ State _____ Zip code _____

HEALTH INSURANCE INFORMATION

Primary Insurance HMO PPO Other

Name of Insurance Plan _____

Name of person who carries insurance _____

Insurance ID# _____

Group # or Name of Employer _____

Date Insurance began _____ Copay \$ _____

Secondary Insurance HMO PPO Other

Name of Insurance Plan _____

Name of person who carries insurance _____

Insurance ID# _____

Group # or Name of Employer _____

Date Insurance began _____ Copay \$ _____

IF COVERED BY INSURANCE THROUGH A SPOUSE OR PARENTS, PLEASE PROVIDE THEIR INFORMATION BELOW

Last Name _____ First Name _____ Middle Initial _____ Male Female

Relationship to patient _____ Date of Birth _____ Social Security# _____

Home Address _____ City _____ State _____ Zip code _____

Phone numbers: Home (_____) _____ Cell (_____) _____ Work (_____) _____ ext _____

E-mail address _____ Occupation _____ Employer name _____

Employer address _____ City _____ State _____ Zip code _____

Last Name _____ First Name _____ Middle Initial _____ Male Female

Relationship to patient _____ Date of Birth _____ Social Security# _____

Home Address _____ City _____ State _____ Zip code _____

Phone numbers: Home (_____) _____ Cell (_____) _____ Work (_____) _____ ext _____

E-mail address _____ Occupation _____ Employer name _____

Employer address _____ City _____ State _____ Zip code _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship to patient _____

Phone numbers: Home (_____) _____ Cell (_____) _____ Work (_____) _____ ext _____

REFERRED BY Name _____ Physician Family/Friend Provider Directory Internet/Website Phone Directory

I have been given a copy of the "Notice of Health Information Practices" and have been given an opportunity to read it and ask questions. _____ (initial)

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I acknowledge that I am responsible and liable for all charges for professional services rendered regardless of my existing medical coverage. In the event my insurance company forwards payment directly to me, I will deliver such payment to Esse Health. I understand that I am responsible for meeting my insurance deductible, coinsurance, and any uncovered services. Should my account become past due, the balance shall become immediately due and payable. I will be held responsible for any fees incurred should my account be placed with a collection agency. I further authorize the release of any medical information necessary to process claims to my insurance company, and hereby assign payment of all medical benefits to Esse Health. My signature signifies that the above information is true to the best of my knowledge.

SIGNATURE of patient or legal guardian _____ DATE _____