

**PEDIATRIC 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 # \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

**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

**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 \$ \_\_\_\_\_

**PARENT OR LEGAL GUARDIAN INFORMATION**

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 noncovered 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 parent or legal guardian \_\_\_\_\_ DATE \_\_\_\_\_