esse HEALTH

We want you well.

ADULT REGISTRATION/UPDATE FORM

TODAY'S DATE _____

PATIENT INFORMATION

Patient's Name _____ [ ] Male [ ] Female [ ] Married [ ] Single [ ] Divorced [ ] Separated
LAST FIRST MI

Date of Birth _____ Age _____ Social Security Number _____
MO DAY YEAR

Home Address _____
STREET CITY STATE ZIP

Phone Numbers: Home _____ Work _____ Cell _____

Email Address _____

Occupation _____ Employer Name _____

Employer Address _____
STREET CITY STATE ZIP

HEALTH INSURANCE INFORMATION

MUST BE COMPLETED FOR ESSE HEALTH TO BILL YOUR INSURANCE COMPANY

PRIMARY INSURANCE

Name of Insurance Plan _____

Name of Person Who Carries Insurance _____

Insurance Identification Number _____

Group Number or Name of Employer _____

Date Insurance Began _____

[ ] HMO [ ] PPO [ ] OTHER

Copay _____

SECONDARY INSURANCE

Name of Insurance Plan _____

Name of Person Who Carries Insurance _____

Insurance Identification Number _____

Group Number or Name of Employer _____

Date Insurance Began _____

[ ] HMO [ ] PPO [ ] OTHER

Copay _____

PLEASE COMPLETE FOR SPOUSE (IF MARRIED) OR PARENT (IF A DEPENDENT)

Name _____ Relationship to Patient _____
LAST FIRST MI

Date of Birth _____ Age _____ Social Security Number _____
MO DAY YEAR

Home Address _____
STREET CITY STATE ZIP

Phone Numbers: Home _____ Work _____ Cell _____

Email Address _____

Occupation _____ Employer Name _____

Employer Address _____
STREET CITY STATE ZIP

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I, _____, acknowledge that I am responsible and liable for all charges accessed for professional services rendered. I acknowledge that I am responsible for all charges 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 deductibles and coinsurance and any noncovered services. Should my account become past due, the balance shall become immediately due and payable. I further authorize the release to my insurance company of any medical information necessary to process a claim, and hereby assign payment of all medical benefits to Esse Health.

Signature _____ Date _____

IN CASE OF URGENT NEED, PLEASE CONTACT THE FOLLOWING PERSON

Name _____ Relationship to Patient _____

Phone Number _____

HOW DID YOU HEAR ABOUT US?

☐ Physician ☐ Friend/Relative
☐ Hospital ☐ Yellow Pages
☐ Insurance Co. ☐ Newspaper
☐ Other _____

Please complete so we may thank them:

Name _____

Address _____