



PEDIATRIC REGISTRATION/UPDATE FORM

- PLEASE PRINT FIRMLY -
- COMPLETE ALL SECTIONS -

CHART NO. _____

TODAY'S DATE _____

PATIENT INFORMATION

Patient's Name _____ Last _____ First _____ MI _____ Male _____
Female _____
Social Security # _____
Date of Birth _____ / _____ / _____ Age _____ Physician _____
MO DAY YEAR

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 _____

PARENT'S INFORMATION

Mother's
Name: _____ Last _____ First _____ MI _____
Social Security Number: _____
Birthdate: _____
Home Address: _____ City _____
State _____ Zip _____
Phone Numbers: Home () _____
Work () _____
Occupation _____
Employer's Name: _____
Employer's Address _____ City _____
State _____ Zip _____

Father's
Name: _____ Last _____ First _____ MI _____
Social Security Number: _____
Birthdate: _____
Home Address: _____ City _____
State _____ Zip _____
Phone Numbers: Home () _____
Work () _____
Occupation _____
Employer's Name: _____
Employer's Address _____ City _____
State _____ Zip _____

PATIENT INFORMATION – Please List All Children We Will Be Caring For

NAME			SEX	DATE OF BIRTH	OFFICE USE	
LAST	FIRST	MI	M/F	MO/DAY/YEAR	CHART NO.	INSURANCE ID#

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.

HOW DID YOU HEAR ABOUT US?

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

Please complete so we may thank them:

Name: _____

Address: _____