Pediatric Psychiatry Registration Form

-PLEASE PRINT FIRMLY-
-COMPLETE ALL SECTIONS-

TODAY'S DATE _____

PATIENT INFORMATION

Patient's Name Last _____ First _____ Middle Initial _____

Social Security Number _____ Home Phone _____ Work Phone _____ Cell Phone _____

E-mail _____ Date of Birth _____ Age _____ Physician _____

Birth Gender	☐	Female	☐	Male	☐	None	☐	Undifferentiated	☐ Unknown
Current Gender	☐	Female	☐	Male	☐	None	☐	Undifferentiated	☐ Unknown
Preferred Pronoun *(optional)*	☐	He, Him, His	☐	She, Her, Hers	☐	They, Them, Theirs	☐	Ze, Hir	
Gender Identity *(optional)*	☐	Female ☐ Female to Male (FTM) Transgender Male/Trans Man	☐	Male ☐ Male to Female (MTF) Transgender Female/Trans Woman	☐	Genderqueer/Non-Binary Neither Exclusively Male or Female ☐ Choose Not to Disclose	☐	Other	
Sexual Orientation *(optional)*	☐	Straight/Heterosexual ☐ Asexual	☐	Lesbian/Gay/Homosexual ☐ Uncertain/Don't Know	☐	Bisexual ☐ Something Else, Please Describe	☐	Other	

HEALTH INSURANCE INFORMATION

MUST BE COMPLETED FOR ESSE HEALTH TO BILL YOUR INSURANCE COMPANY

PRIMARY INSURANCE		SECONDARY INSURANCE	
Name of Insurance Plan		Name of Insurance Plan	
Name of Person Who Carries Insurance		Name of Person Who Carries Insurance	
Insurance Identification Number		Insurance Identification Number	
Group Number or Name of Employer		Group Number or Name of Employer	
Date Insurance Began		Date Insurance Began	
COPAY		COPAY	

PARENTS INFORMATION

Parent 1 Name _____
Last First MI

Social Security Number _____
Birthdate _____
Home Address _____
City _____ State _____ Zip _____
Phone Numbers Home ( )_____ Cell ( )_____ Work ( )_____
Email Address _____
Occupation _____
Employer's Name _____
Employer's Address _____
City _____ State _____ Zip _____

Parent 2 Name _____
Last First MI

Social Security Number _____
Birthdate _____
Home Address _____
City _____ State _____ Zip _____
Phone Numbers Home ( )_____ Cell ( )_____ Work ( )_____
Email Address _____
Occupation _____
Employer's Name _____
Employer's Address _____
City _____ State _____ Zip _____

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

I, _____, acknowledge that I am responsible and liable for all charges assessed 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 non-covered 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 _____

HOW DID YOU HEAR ABOUT US?

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

Please complete so we may thank them: Name _____ Address _____