



*We want you well.*

Welcome to Esse Health!

At Esse Health, we are dedicated to patient satisfaction, service and value. Our Mission is to place you and your physician at the center of every health care decision. We know your choice of a physician is an important decision, and we are committed to providing the highest quality care by working with you to maximize your health. We call it patient-centered care.

What does patient-centered care mean for you? It means you have a team of health care professionals, led by your physician, who can help you be more involved in your health care and take better care of yourself. It means you have access to resources like our Patient Portal that allows you to ask a medical question, request an appointment or refill a medication at times that are convenient for you. And it means we provide the highest quality care in the most cost effective way.

Thank you for choosing Esse Health as your partner in healthcare. We are committed to you and your family's good health.

Best Wishes,

Dave Kearney  
Chief Executive Officer  
Esse Health



## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize the use or disclosure of the above-named individual's health information as described below.

### INFORMATION TO BE RELEASED BY:

### INFORMATION TO BE RELEASED TO:

\_\_\_\_\_  
Organization/Person Name

\_\_\_\_\_  
Organization/Person Name

\_\_\_\_\_  
Address City, State, Zip

\_\_\_\_\_  
Address City, State, Zip

### TYPE OF MEDICAL INFORMATION TO BE DISCLOSED

- |                                                                                                         |                                                       |                                          |
|---------------------------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Complete Medical Record                                                        | <input type="checkbox"/> List of Allergies            | <input type="checkbox"/> X-ray reports   |
| <input type="checkbox"/> Physician Progress Notes                                                       | <input type="checkbox"/> Problem list                 | <input type="checkbox"/> EKG             |
| <input type="checkbox"/> Immunization Records                                                           | <input type="checkbox"/> Lab Reports                  | <input type="checkbox"/> Medication list |
| <input type="checkbox"/> Consultation Reports                                                           | <input type="checkbox"/> Other (please specify) _____ |                                          |
| <input type="checkbox"/> My health information relating only to the following treatment/condition _____ |                                                       |                                          |
| <input type="checkbox"/> My health information only for the following dates: _____                      |                                                       |                                          |

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It also may include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby **specifically authorized to release** all information or medical records relating to such diagnosis, testing or treatment, unless specifically excluded below.

\_\_\_\_\_  
I understand I have a right to cancel this authorization at any time. I understand if I wish to withdraw this authorization, I must do so in writing. I must present my written cancellation to the health information management department. I understand the authorization withdrawal will not apply to information that has already been released due to this authorization. I understand the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise cancelled, this authorization will expire on the following date or event \_\_\_\_\_. If I fail to specify an expiration date or event, this authorization will expire in six months.

I understand authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I do not have to sign this form to receive treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand any disclosure of information carries with it the possibility for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact my physician's office manager. I understand there may be a charge associated with copying my health information.

\_\_\_\_\_  
Signature of Patient/Legal Representative

\_\_\_\_\_  
Date



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**AUTHORIZATION TO COMMUNICATE INFORMATION TO PATIENT**

The undersigned authorizes Esse Health, its physicians, staff and representatives to communicate with me by leaving messages related to my healthcare at the following numbers:

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

**AUTHORIZATION TO COMMUNICATE INFORMATION TO OTHERS**

The undersigned authorizes Esse Health, its physicians, staff and representatives to communicate information about my health with the following:

1. Name: \_\_\_\_\_ Home #: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Work #: \_\_\_\_\_  
May Discuss Diagnosis/Treatment: Yes \_\_\_\_\_ No \_\_\_\_\_  
May Discuss Billing Info: Yes \_\_\_\_\_ No \_\_\_\_\_
2. Name: \_\_\_\_\_ Home #: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Work #: \_\_\_\_\_  
May Discuss Diagnosis/Treatment: Yes \_\_\_\_\_ No \_\_\_\_\_  
May Discuss Billing Info: Yes \_\_\_\_\_ No \_\_\_\_\_

I understand that these authorizations are voluntary and that I can refuse to sign the authorization. I understand I may revoke this authorization at any time. I understand I do not have to sign this form to receive care. I understand it is my responsibility to update this list in order to keep accurate who can obtain information about my health.

\_\_\_\_\_  
Patient/Legal Representative

Date: \_\_\_\_\_

**SIGN BELOW ONLY IF YOU WISH TO REVOKE YOUR AUTHORIZATION**

**I hereby revoke this authorization.**

\_\_\_\_\_  
Patient/Legal Representative

Date: \_\_\_\_\_



## ADULT REGISTRATION/UPDATE FORM

### PATIENT INFORMATION

TODAY'S DATE \_\_\_\_\_

|                    |                                                     |                                                          |                                                             |                                                                             |                                  |
|--------------------|-----------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------------------------------|----------------------------------|
| Last Name          |                                                     | First Name                                               |                                                             | Middle Initial                                                              |                                  |
| Home Phone         |                                                     | Work Phone                                               |                                                             | Cell Phone                                                                  |                                  |
| E-mail Address     |                                                     | Date of Birth                                            |                                                             | Age                                                                         |                                  |
| Home Address       | Street                                              | City                                                     | State                                                       | Zip                                                                         |                                  |
| Occupation         |                                                     | Employer Name                                            |                                                             | Zip                                                                         |                                  |
| Employer Address   | Street                                              | City                                                     | State                                                       |                                                                             |                                  |
| Birth Sex          | <input type="checkbox"/> Female                     | <input type="checkbox"/> Male                            | <input type="checkbox"/> None                               | <input type="checkbox"/> Undifferentiated                                   | <input type="checkbox"/> Unknown |
| Current Gender     | <input type="checkbox"/> Female                     | <input type="checkbox"/> Male                            | <input type="checkbox"/> None                               | <input type="checkbox"/> Undifferentiated                                   |                                  |
| Gender Identity    | <input type="checkbox"/> Female                     | <input type="checkbox"/> Male                            | <input type="checkbox"/> Genderqueer/Non-Binary             | <input type="checkbox"/> Choose Not to Disclose                             |                                  |
|                    | <input type="checkbox"/> Female-to-Male (FTM)       | <input type="checkbox"/> Male-to-Female (MTF)            | <input type="checkbox"/> Neither Exclusively Male or Female | <input type="checkbox"/> Additional Gender Category or Other Please Specify |                                  |
|                    | <input type="checkbox"/> Transgender Male/Trans Man | <input type="checkbox"/> Transgender Female/Trans Woman  |                                                             |                                                                             |                                  |
| Sexual Orientation | <input type="checkbox"/> Straight or Heterosexual   | <input type="checkbox"/> Lesbian, Gay or Homosexual      | <input type="checkbox"/> Bisexual                           | <input type="checkbox"/> None                                               |                                  |
|                    | <input type="checkbox"/> Don't Know                 | <input type="checkbox"/> Something Else, Please Describe | <input type="checkbox"/> Choose Not to Disclose             |                                                                             |                                  |
| Preferred Pronoun  | <input type="checkbox"/> She, Her, Hers             | <input type="checkbox"/> He, Him, His                    | <input type="checkbox"/> They, Them, Theirs                 | <input type="checkbox"/> Ze, Hir                                            |                                  |
|                    | <input type="checkbox"/> Other                      | <input type="checkbox"/> None                            | <input type="checkbox"/> Asked, but Unknown                 | <input type="checkbox"/> Decline to Answer                                  |                                  |
| Marital Status     | <input type="checkbox"/> Single                     | <input type="checkbox"/> Married                         | <input type="checkbox"/> Divorced                           | <input type="checkbox"/> Legally Separated                                  |                                  |
|                    | <input type="checkbox"/> Annulled                   | <input type="checkbox"/> Widowed                         | <input type="checkbox"/> Interlocutory                      | <input type="checkbox"/> Life Partner                                       |                                  |
|                    | <input type="checkbox"/> Domestic Partner           | <input type="checkbox"/> Polygamous                      | <input type="checkbox"/> Unknown                            |                                                                             |                                  |

### 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                 | _____ |
| [ ] HMO [ ] PPO [ ] OTHER            | _____ | [ ] HMO [ ] PPO [ ] OTHER            | _____ |
| COPAY                                | _____ | COPAY                                | _____ |

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

|                  |               |                |                         |     |
|------------------|---------------|----------------|-------------------------|-----|
| Last Name        | First Name    | Middle Initial | Relationship to Patient |     |
| Home Phone       | Work Phone    |                | Cell Phone              |     |
| E-mail Address   | Date of Birth |                | Age                     |     |
| Home Address     | Street        | City           | State                   | Zip |
| Occupation       |               | Employer Name  |                         |     |
| Employer Address | Street        | City           | State                   | Zip |



## ADULT REGISTRATION/UPDATE FORM

### PATIENT INFORMATION

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#### ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

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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 \_\_\_\_\_

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#### IN CASE OF URGENT NEED, PLEASE CONTACT THE FOLLOWING PERSON

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Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Phone Number \_\_\_\_\_

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#### HOW DID YOU HEAR ABOUT US?

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- |                                                |                                          |
|------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Physician             | <input type="checkbox"/> Friend/Relative |
| <input type="checkbox"/> Hospital              | <input type="checkbox"/> Yellow Pages    |
| <input type="checkbox"/> Internet/Social Media | <input type="checkbox"/> Newspaper       |
| <input type="checkbox"/> Insurance Company     | <input type="checkbox"/> Other _____     |

Date: \_\_\_\_\_



Last Name

First Name

Date of Birth

## PATIENT DEMOGRAPHIC QUESTIONNAIRE

Please note that we are requesting this optional information as an attempt to comply with Federal “Meaningful Use” guidelines, as released by The Office of the National Coordinator for Health Information Technology. More information regarding these guidelines is available at <http://healthit.hhs.gov>.

You are NOT obligated to respond in order to be treated.

If you do not wish to provide this information, please simply fill in your name, date and select the “Decline to Respond” choice.

Please select the below as appropriate:

### RACE

- |                                                                 |                                             |
|-----------------------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Asian                                  | <input type="checkbox"/> White              |
| <input type="checkbox"/> American Indian or Alaska Native       | <input type="checkbox"/> Decline to Specify |
| <input type="checkbox"/> Black or African American              | <input type="checkbox"/> Other Race         |
| <input type="checkbox"/> Native Hawaiian/Other Pacific Islander |                                             |

### PREFERRED LANGUAGE

- |                                                  |                                             |
|--------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> English                 | <input type="checkbox"/> Korean             |
| <input type="checkbox"/> Spanish                 | <input type="checkbox"/> Somali             |
| <input type="checkbox"/> Bosnian                 | <input type="checkbox"/> Arabic             |
| <input type="checkbox"/> Russian                 | <input type="checkbox"/> Spanish Castilian  |
| <input type="checkbox"/> Italian                 | <input type="checkbox"/> Vietnamese         |
| <input type="checkbox"/> French                  | <input type="checkbox"/> Hindi              |
| <input type="checkbox"/> German                  | <input type="checkbox"/> Polish             |
| <input type="checkbox"/> Chinese                 | <input type="checkbox"/> Thai               |
| <input type="checkbox"/> Japanese                | <input type="checkbox"/> Other              |
| <input type="checkbox"/> Central Khme            | <input type="checkbox"/> Bulgarian          |
| <input type="checkbox"/> Haitian; Haitian Creole | <input type="checkbox"/> Urdu               |
| <input type="checkbox"/> Hebrew                  | <input type="checkbox"/> Swahili            |
| <input type="checkbox"/> Portuguese              | <input type="checkbox"/> Decline to Specify |

### ETHNICITY

- ☐ Hispanic or Latino  
☐ Not Hispanic or Latino  
☐ Decline to Specify

### CONTACT PREFERENCE

- ☐ Cell Phone  
☐ Confidential  
☐ Email/Portal  
☐ Home Phone  
☐ Mail  
☐ Work Phone  
☐ Decline to Specify