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	☐ Female	☐ Male	☐ None ☐ Undifferentiated	☐ Unknown
Current Gender	☐ Female	☐ Male	☐ None ☐ Undifferentiated	
Gender Identity	☐ 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 ☐ Additional Gender Category or Other Please Specify
Sexual Orientation	☐ Straight or Heterosexual ☐ Don't Know	☐ Lesbian, Gay or Homosexual ☐ Something Else, Please Describe	☐ Bisexual ☐ Choose Not to Disclose	☐ None
Preferred Pronoun	☐ She, Her, Hers ☐ Other	☐ He, Him, His ☐ None	☐ They, Them, Theirs ☐ Asked, but Unknown	☐ Ze, Hir ☐ Decline to Answer
Marital Status	☐ Single ☐ Annulled ☐ Domestic Partner	☐ Married ☐ Widowed ☐ Polygamous	☐ Divorced ☐ Interlocutory ☐ Unknown	☐ Legally Separated ☐ Life Partner

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

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

- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☐ Other Race
- ☐ Decline to Specify

ETHNICITY

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

PREFERRED LANGUAGE

- ☐ English
- ☐ Spanish
- ☐ Bosnian
- ☐ Russian
- ☐ Italian
- ☐ French
- ☐ German
- ☐ Chinese
- ☐ Japanese
- ☐ Central Khme
- ☐ Haitian; Haitian Creole
- ☐ Hebrew
- ☐ Portuguese
- ☐ Korean
- ☐ Somali
- ☐ Arabic
- ☐ Spanish Castilian
- ☐ Vietnamese
- ☐ Hindi
- ☐ Polish
- ☐ Thai
- ☐ Other
- ☐ Bulgarian
- ☐ Urdu
- ☐ Swahili
- ☐ Decline to Specify

CONTACT PREFERNCE

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

ACKNOWLEDGEMENT OF RECEIPT

PATIENT'S NAME: _____

DATE OF BIRTH: _____

I HAVE BEEN GIVEN A COPY OF THE ESSE HEALTH NOTICE OF PRIVACY PRACTICES. I HAVE READ AND UNDERSTAND THE INFORMATION CONTAINED IN THE NOTICE. I ALSO UNDERSTAND THAT IF I HAVE ANY QUESTIONS, I MAY CALL MY PHYSICIAN'S OFFICE MANAGER OR CONTACT PRIVACYOFFICER@ESSEHEALTH.COM FOR CLARIFICATION.

_____ _____

SIGNATURE OF PATIENT/GARDIAN/AUTHORIZED REPRESENTATIVE DATE

RELATIONSHIP, IF NOT PATIENT: _____

ADULT REGISTRATION/UPDATE FORM

PATIENT INFORMATION

ACKNOWLEDGMENT OF FINANCIAL RESPOSIBILITY

I, _____, acknowledge that I am responsible and liable for all charges assessed for professional services rendered. I acknowledge that I am responsible for all my 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 sue, the balance shall become immediately sue 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(S): _____

HOW DID YOU HEAR ABOUT US?

- ☐ PHYSICIAN
- ☐ HOSPITAL
- ☐ INTERNET/SOCIAL MEDIA
- ☐ INSURANCE COMPANY
- ☐ FRIEND/RELATIVE
- ☐ YELLOW PAGES
- ☐ NEWSPAPER
- ☐ OTHER: _____

LAST NAME | FIRST NAME | MIDDLE INITIAL | DATE OF BIRTH

EMPLOYER | OCCUPATION | YEAR RETIRED

MEDICAL DOCTOR | DOCTOR'S ADDRESS | OFFICE PHONE NUMBER

PREFERRED PHARMACY NAME | PHARMACY PHONE NUMBER | PHARMACY ADDRESS

ALTERNATIVE PHARMACY NAME | PHARMACY PHONE NUMBER | PHARMACY ADDRESS

MEDICATIONS & VITAMINS

Please list all your medications, prescription and nonprescription, and the dosage amount:

MEDICATIONS	DOSAGE, HOW TAKEN
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Please list medication **ALLERGIES** or medications you cannot take. Check here if **NO ALLERGIES** ☐

1.	2.
3.	4.
5.	6.
7.	8.

SOCIAL HISTORY

DO YOU USE TOBACCO? **YES** / **NO** / **FORMER**

TYPE OF TOBACCO USED (CIGARS, CANS, CIGARETTES, ETC.)? _____

AMOUNT PER DAY? _____ AGE START? _____ AGE STOPPED? _____

DO YOU DRINK ALCOHOL? **YES** / **NO** / **FORMER** DATE QUIT: _____

AMOUNT: _____ TYPE: _____ HOW OFTEN: _____

NAME: _____ DOB: _____

PAST MEDICAL HISTORY

CONDITION	SELF	FAMILY MEMBER
ASTHMA		
BLEEDING DISORDER		
DEMENTIA/ALZHEIMER'S		
DIABETES		
BLOOD CLOT		
EMPHYSEMA/COPD		
HEART DISEASE		
HEART ATTACK		
HEPATITIS C		
HIGH BLOOD PRESSURE		
KIDNEY DISEASE		
VASCULAR PROBLEMS		
LIVER DISEASE		
LUNG PROPLEMS		
MENTAL ILLNESS		
PACEMAKER/DIFIBULATOR		
PNEUMONIA		
RHEUMATOID ARTHRITIS		
SEIZURE/EPILEPSY		
STROKE		
ULCER		
CANCER	**TYPE:** _____	**TYPE:** _____

OTHER MEDICAL CONDITIONS (PLEASE LIST): _____

_____

PREVIOUS SURGERYS:

KNEE REPLACEMENT-DATE: _____
HIP REPLACEMENT-DATE: _____
SHOULDER REPLACEMENT-DATE: _____
MENISCAL TEAR-DATE: _____
ROTATOR CUFF REPAIR-DATE: _____
CARPAL TUNNEL RELEASE-DATE: _____

OTHER SURGERIES: _____

_____

LIST PREVIOUS FRACTURES/BROKEN BONES: _____

_____

NAME: _____ DOB: _____

EMERGENCY CONTACT: _____ PHONE: _____

PRIMARY CARE PHYSICIAN: _____

HEIGHT: _____ WEIGHT: _____ ARE YOU A VETERAN? **YES** OR **NO**

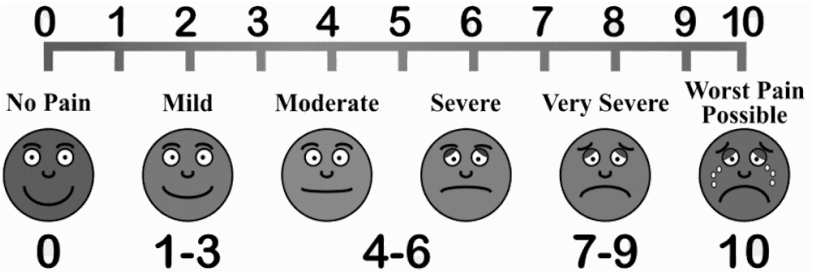
HISTORY OF PRESENT ILLNESS

WHAT **BODY PART** ARE YOU HERE FOR: **RIGHT** / **LEFT** / **BOTH**

☐ SHOULDER ☐ ELBOW ☐ WRIST ☐ HAND/FINGER(S) ☐ OTHER: _____

☐ HIP ☐ KNEE ☐ ANKLE ☐ FOOT/TOE(S) ☐ BACK (**UPPER** / **MIDDLE** / **LOWER**)

RATE YOUR PAIN LEVEL:
(PLEASE CIRCLE A NUMBER)



ONSET **DATE** OF SYMPTOMS: _____/_____/_____

WAS THIS AN INJURY? **YES** OR **NO** IF YES, **HOW?**_____

DESCRIBE THE ONSET / INJURY: _____

☐ ACHE ☐ NUMBNESS ☐ PINS & NEEDLES ☐ BURNING

☐ STABBING ☐ RADIATING PAIN: **WHERE?** _____ ☐ OTHER: _____

WERE YOU SEEN IN A HOSPITAL OR ER? **YES** OR **NO** FACILITY: _____

WERE X-RAYS / MRI / TESTING DONE? **YES** OR **NO**. DID YOU BRING IMAGING TODAY? **YES** OR **NO**

INJURY COMPENSATION

WERE YOU ON THE JOB WHEN THIS INJURY OCCURRED? **YES** OR **NO**

HAVE YOU FILED A WORKERS COMPENSATION CLAIM? **YES** OR **NO**

LIABILITY CASE? **YES** OR **NO** ATTORNEYS NAME: _____

_____ _____

PATIENT / PARENT CARE GIVER SIGNATURE **DATE**

PATIENT NAME: _____ DOB: _____

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 number:

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 ____

3. 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.

_____ Date: _____
Patient/Legal Representative

SIGN BELOW ONLY IF YOU WISH TO REVOKE YOUR AUTHORIZATION

I hereby revoke this authorization.

_____ DATE: _____
Patient /Legal Representative