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. The National Committee on Quality Assurance (NCQA) has recognized Esse Health as a Level 3 Patient-Centered Medical Home.

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

□ Complete Medical Record	□ List of Allergies	□ X-ray reports
□ Physician Progress Notes	□ Problem list	□ EKG
□ Immunization Records	□ Lab Reports	□ Medication list
□ Consultation Reports	□ Other (please specify) _____	

□ My health information relating only to the following treatment/condition_____

□ 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 / LEGAL REPRESENTATIVE

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

Patient/Parent/Guardian Name: _____ Cell:_____ Home : _____
Work: _____ E-Mail:_____

Patient/Parent/Guardian Name: _____ Cell:_____ Home : _____
Work: _____ E-Mail:_____

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.

_____ Date:_____
Patient/Legal Representative

SIGN BELOW ONLY IF YOU WISH TO REVOKE YOUR AUTHORIZATION

I hereby revoke this authorization.

_____ **Date:** _____
Patient/Legal Representative

PEDIATRIC REGISTRATION/UPDATE FORM

-PLEASE PRINT FIRMLY-
-COMPLETE ALL SECTIONS-

TODAY'S DATE _____

PATIENT INFORMATION

Patient's Name Last _____ First _____ Middle Initial _____

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	☐	Male	☐	Genderqueer/Non-Binary Neither Exclusively Male or Female	☐	Other	
	☐	Female to Male (FTM) Transgender Male/Trans Man	☐	Male to Female (MTF) Transgender Female/Trans Woman	☐	Choose Not to Disclose			
Sexual Orientation *(optional)*	☐	Straight/Heterosexual	☐	Lesbian/Gay/Homosexual	☐	Bisexual	☐	Other	
	☐	Asexual	☐	Uncertain/Don't Know	☐	Something Else, Please Describe			

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

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

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 _____

Pediatric and Adolescent Medicine
New Patient Health History

Today's Date: ___/___/___
Primary pediatrician: _____

Patient's Full Name:_____ ☐ male ☐ female Birth Date: ___/___/___

Name of person completing this form:_____ Relationship to patient:_____

Please list patient's current medical diagnoses: ☐None

Please list all medicines/vitamins/supplements: ☐None

Please list any medicine/food/latex allergies: ☐None

This patient has: *(Please include details)*

-been in a hospital overnight? ☐Y

-gone to the emergency room? ☐Y

-gone to an urgent care center? ☐Y

-had an allergic reaction? (medication, food, insect) ☐Y

-had surgery? (an operation) ☐Y

-seen a medical specialist or doctor elsewhere? ☐Y

-traveled outside of the U.S.? ☐Y

Today I have concerns about:

Headaches/Head Injury?..... ☐Y
Vision/Hearing?..... ☐Y
Dental? ..... *(Brushes?* ☐Y ☐ N*, Sees dentist?*☐Y☐ N*)* .....☐Y
Ears/Eyes/Nose/Throat? ..... ☐Y
Allergies?..... ☐Y
Cough/Wheeze/Trouble breathing? ..... ☐Y
Chest pain?..... ☐Y
Abdominal pain?..... ☐Y
Stools or Urination?..... ☐Y
Genitals?..... ☐Y
Muscles/Joints/Bones?..... ☐Y
Skin?..... ☐Y
Abnormal Bleeding or Bruising?..... ☐Y
Sleep?...*(at least 10-12h preschool, 10h 5-12y, 9-10h teens)*..... ☐Y
Development?..... ☐Y
Behavior/Mental Health?..... ☐Y
Learning/School Performance?..... ☐Y
Nutrition?..... ☐Y
Weight/Growth?..... ☐Y
Substance use/abuse?..... ☐Y
Sexual activity?..... ☐Y
Other? *(Include details)*..... ☐Y

For girls: Has she started her period? ☐N ☐Y, at age _____
If yes, when did the last period start? ___/___/___
Is she having any problems? ☐N ☐Y:

	Parent/Guardian #1	Parent/Guardian #2
Name:		
Preferred contact #:		
Occupation:		

Parents are: ☐Married ☐Divorced ☐Separated ☐Single ☐Other:

Child lives with: ☐Both parents ☐Other: _____
☐Parent #1_____% (☐*remarried*) ☐Parent #2_____% (☐*remarried*)

Others in the home: *(name/age/relationship)*

Recent family changes or stress? ☐ N ☐Y:

Patient attends:
☐**Daycare** ☐Sitter ____ days/week at _____
☐**Preschool** ____ days/week at _____
☐**School**, in Grade:____ at _____
---Child's school performance/grades/GPA: _____
Does your child receive any special services? ☐N ☐Y
☐IEP ☐504 ☐Gifted ☐Therapy ☐Other:

Patient's sports/activities/hobbies:

Concerns about relationships w/ friends, family, others? ☐N ☐Y

Home Environment/Safety: What year was your home built? _____
☐House ☐Apartment ☐Condo ☐Trailer ☐Other:
Are there: Carbon monoxide detectors? ☐Y
----------Smoke detectors? ☐Y
----------Fire extinguishers? ☐Y
----------Pool? ☐Y Locked? _____How? _____
--Pets/Animals? ☐Y What kind? _____
---------Firearms? ☐Y How are they stored?_____
-- ------Smokers? ☐Y Who smokes? _____ Where? _____

Does your child: -wear a helmet appropriately? ☐Y
-use sunscreen appropriately *(SPF 15 or above)*? ☐Y
-know how to swim *(or take lessons if 4 or older)*? ☐Y

When riding in a car, my child uses:
☐Rear-facing car seat *(<2y)*
☐Front-facing car seat *(until weight exceeds seat specifications)*
☐Booster *(belt positioning booster seat until 4'9")*
☐Seat Belt in back seat ☐Seat belt in front seat *(>12y)*

(Please complete other side) kkn 09/09/16

Patient Name: _____ DOB: _____/_____/_____ Today's Date: _____/_____/_____

Please record your child's Family Medical History below:

☐ I have multiple children here TODAY and have completed this TODAY on the form of child: _____

☐ Patient adopted; No **Biologic** Family History available.

☐ Patient adopted; Limited **Biologic** Family History recorded below.

☐ Patient conceived by IVF with donor ☐Egg ☐Sperm (only include details of blood relatives below)

Have any blood relatives of THIS PATIENT had these conditions? (parents, siblings, grandparents, aunts, uncles)

-**Please include details for all YES answers including which relatives and whether on father's or mother's side.**

ADD/ADHD……☐ Y:

Alcoholism ……☐ Y:

Allergies……☐ Y:

Asthma……☐ Y:

Birth Defects ……☐ Y:

Blood/Bleeding disorders……☐ Y:

Bowel Disease……☐ Y:

(Ulcerative colitis, Crohn's, Irritable Bowel)

Cancer (*include type*) ……☐ Y:

Deafness……☐ Y:

Depression……☐ Y:

Developmental delays……☐ Y:

Diabetes (*Type 1 or Type 2?*)……☐ Y:

Early death/SIDS……☐ Y:

Eczema……☐ Y:

Family or inherited diseases……☐ Y:

Heart attack before age 55……☐ Y:

Heart disease……☐ Y:

High cholesterol/lipids/triglycerides……☐ Y:

High blood pressure……☐ Y:

Hip dysplasia……☐ Y:

Immune disorders……☐ Y:

Intellectual Disability……☐ Y:

Kidney Disease……☐ Y:

Learning Disability……☐ Y:

Liver Disease……☐ Y:

Lung Disease……☐ Y:

Mental Health *(Anxiety, Bipolar, Depression, etc.)* .☐ Y:

Metabolic Disorders……☐ Y:

Migraines……☐ Y:

Neurologic disease……☐ Y:

Obesity……☐ Y:

Scoliosis……☐ Y:

Seizures/Epilepsy……☐ Y:

Serious or fatal childhood illness……☐ Y:

Strabismus ("Lazy eye") ……☐ Y:

Substance abuse……☐ Y:

Thyroid disease……☐ Y:

Tuberculosis……☐ Y:

Other……☐ Y:

Thank you for completing this information.

Date: _____

Patient Information Sheet

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
- ☐ Greek
- ☐ Alaskan Native
- ☐ Hawaiian
- ☐ American Indian or Alaskan Native
- ☐ Hispanic
- ☐ Black/African American
- ☐ Indian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Multiracial
- ☐ White
- ☐ Native American Indian
- ☐ More than one race
- ☐ Other Pacific Islander (Not Hawaiian)
- ☐ Other race
- ☐ Pacific Islander
- ☐ Unknown
- ☐ 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

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