ADULT REGISTRATION/UPDATE FORM

TODAY'S DATE ____________

PATIENT INFORMATION

Patient's Name ______________________________ (LAST / FIRST / MI)

[ ] Male [ ] Female
[ ] Married [ ] Single
[ ] Divorced [ ] Separated

Date of Birth ____________ (MO / DAY / YEAR) Age ________ Social Security Number ______________

Home Address ______________________________ (STREET / CITY / STATE / ZIP)

Phone Numbers: Home ____________ Work ____________ Cell ____________

Email Address ______________________________

Occupation ______________ Employer Name ______________

Employer Address ______________________________ (STREET / CITY / STATE / ZIP)

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 ______________

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

Name ______________________________ (LAST / FIRST / MI) Relationship to Patient ______________

Date of Birth ____________ (MO / DAY / YEAR) Age ________ Social Security Number ______________

Home Address ______________________________ (STREET / CITY / STATE / ZIP)

Phone Numbers: Home ____________ Work ____________ Cell ____________

Email Address ______________________________

Occupation ______________ Employer Name ______________

Employer Address ______________________________ (STREET / CITY / STATE / ZIP)

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.

Signature ______________________________ Date ______________

IN CASE OF URGENT NEED, PLEASE CONTACT THE FOLLOWING PERSON

Name ______________________________ Relationship to Patient ______________

Phone Number ______________________________

HOW DID YOU HEAR ABOUT US?

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

Please complete so we may thank them:

Name ______________________________

Address ______________________________

FORM 100 (REV 1/11)