



We want you well.

ADULT REGISTRATION/UPDATE FORM

PATIENT INFORMATION

TODAY'S DATE _____

Form fields for Patient Information including Last Name, First Name, Middle Initial, Home Phone, Work Phone, Cell Phone, E-mail Address, Date of Birth, Age, Home Address, City, State, Zip, Social Security Number, Occupation, Employer Name, Zip, Employer Address, Street, City, State, Birth Sex, Current Gender, Gender Identity, Sexual Orientation, Preferred Pronoun, Marital Status.

HEALTH INSURANCE INFORMATION

MUST BE COMPLETED FOR ESSE HEALTH TO BILL YOUR INSURANCE COMPANY

Form fields for Health Insurance Information divided into PRIMARY INSURANCE and SECONDARY INSURANCE sections, including Name of Insurance Plan, Name of Person Who Carries Insurance, Insurance Identification Number, Group Number or Name of Employer, Date Insurance Began, and COPAY.

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

Form fields for Spouse or Parent information including Last Name, First Name, Middle Initial, Relationship to Patient, Home Phone, Work Phone, Cell Phone, E-mail Address, Date of Birth, Age, Home Address, City, State, Zip, Social Security Number, 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

- | | |
|--|---|
| <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 |

CONTACT PREFERENCE

- 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 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 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 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(S): _____

HOW DID YOU HEAR ABOUT US?

- | | |
|--|--|
| <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: _____ |



 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**

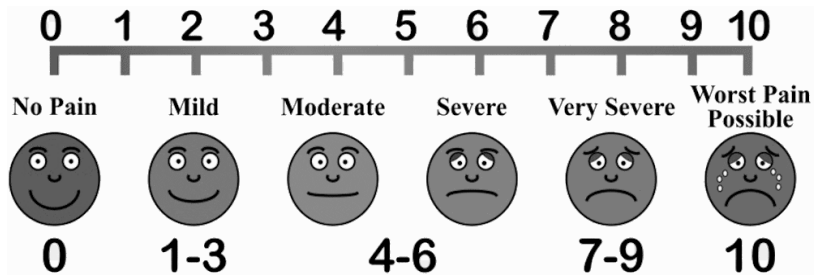
HISTORY OF PRESENT ILLNESS



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.

Patient/Legal Representative

Date: _____

SIGN BELOW ONLY IF YOU WISH TO REVOKE YOUR AUTHORIZATION	
I hereby revoke this authorization.	
_____ Patient /Legal Representative	DATE: _____