

**GATEWAY ASTHMA AND ALLERGY/ESSE HEALTH  
ADULT REGISTRATION/UPDATE FORM**

**PATIENT INFORMATION**

Patient's name \_\_\_\_\_ ( ) male ( ) female  
last first mi ( ) married  
( ) single  
Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Social security # \_\_\_\_\_ ( ) divorced  
mo day yr ( ) separated  
( ) widowed  
Home address \_\_\_\_\_  
street city state zip  
Phone numbers: Home (\_\_\_\_) \_\_\_\_\_ Work(\_\_\_\_) \_\_\_\_\_ ext \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer name \_\_\_\_\_  
Employer address \_\_\_\_\_  
street city state zip

**HEALTH INSURANCE INFORMATION**

PRIMARY INSURANCE ( ) HMO ( ) PPO ( ) other	SECONDARY INSURANCE ( ) HMO ( ) PPO ( ) other
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 _____ Copay \$ _____	Date insurance began _____ Copay \$ _____

**Please provide the following information on spouse if married or parent if a dependent**

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
last first mi  
Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social security # \_\_\_\_\_ Occupation \_\_\_\_\_  
mo day yr  
Home address \_\_\_\_\_  
street city state zip  
Phone numbers: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ ext \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_  
Employer name \_\_\_\_\_ Address \_\_\_\_\_  
street city state zip

**In case of urgent need, who can we contact?**

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Phone numbers: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ ext \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

**Were you referred to us? (circle) Physician/Friend/Patient Name \_\_\_\_\_ Yellow pages – Ad – Hospital**

I have been given a copy of the "Notice of Health Information Practices" and have been given an opportunity to read it and ask questions. \_\_\_\_\_  
(Initial)

**ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY**

I acknowledge that I am responsible and liable for all charges for professional services rendered 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, coinsurance, and any noncovered services. Should my account become past due, the balance shall become immediately due and payable. I will be held responsible for any fees incurred should my account be placed with a collection agency. I further authorize the release of any medical information necessary to process claims to my insurance company, and hereby assign payment of all medical benefits to Esse Health.

My signature signifies that the above information is true to the best of my knowledge.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
Patient or Legal Guardian Signature

