

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

PATIENT INFORMATION

Patient's name _____ () male () female
last first mi
Date of birth ____/____/____ Age ____ Social security # _____
Home 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 \$ _____

PARENTS' INFORMATION

Mother's name _____ DOB ____/____/____ Social security # _____
last first mi mo day yr
Home address _____
street city state zip

Phone numbers: Home (____) _____ Work (____) _____ ext _____ Cell (____) _____

Occupation _____ Employer name _____

Employer address _____
street city state zip

Father's name _____ DOB ____/____/____ Social security # _____
last first mi mo day yr

Home address _____
street city state zip

Phone numbers: Home (____) _____ Work (____) _____ ext _____ Cell (____) _____

Occupation _____ Employer name _____

Employer address _____
street city state zip

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 to the above named child 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 _____
Parent or Legal Guardian Signature