ADULT REGISTRATION / UPDATE FORM
Saint Louis Allergy and Asthma

PATIENT INFORMATION

Patient's Last Name _____ First Name _____ Middle Initial _____ ☐ Male ☐ Female

Date of Birth _____ Age _____ Social Security # _____ ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Ethnicity: ☐Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Disclose
Race: ☐Asian ☐American Indian or Alaskan Native ☐Black/African American ☐Native Hawaiian/other Pacific Islander ☐White ☐More than one race ☐Other race ☐Decline to Disclose
Preferred Language: ☐English ☐Spanish ☐Bosnian ☐Russian ☐Italian ☐French ☐German ☐Chinese ☐Japanese ☐Korean ☐Vietnamese ☐Hindi ☐Polish ☐Thai ☐Other

Home Address _____ City_____ State_____ Zip code_____

Phone numbers: Home (_____)_____ Cell (_____)_____ Work (_____)_____ext_____

E-mail address_____ Occupation_____ Employer name_____

Employer address_____ City_____ State_____ Zip code_____

HEALTH INSURANCE INFORMATION

Primary Insurance ☐HMO ☐PPO ☐Other
Name of Insurance Plan _____
Name of person who carries insurance_____
Insurance ID# _____
Group # or Name of Employer_____
Date Insurance began_____ Copay $_____

Secondary Insurance ☐HMO ☐PPO ☐Other
Name of Insurance Plan _____
Name of person who carries insurance_____
Insurance ID# _____
Group # or Name of Employer_____
Date Insurance began_____ Copay $_____

IF COVERED BY INSURANCE THROUGH A SPOUSE OR PARENTS, PLEASE PROVIDE THEIR INFORMATION BELOW

Last Name _____ First Name _____ Middle Initial _____ ☐ Male ☐ Female

Relationship to patient_____ Date of Birth_____ Social Security#_____

Home Address _____ City_____ State_____ Zip code_____

Phone numbers: Home (_____)_____ Cell (_____)_____ Work (_____)_____ext_____

E-mail address_____ Occupation_____ Employer name_____

Employer address_____ City_____ State_____ Zip code_____

Last Name _____ First Name _____ Middle Initial _____ ☐ Male ☐ Female

Relationship to patient_____ Date of Birth_____ Social Security#_____

Home Address _____ City_____ State_____ Zip code_____

Phone numbers: Home (_____)_____ Cell (_____)_____ Work (_____)_____ext_____

E-mail address_____ Occupation_____ Employer name_____

Employer address_____ City_____ State_____ Zip code_____

EMERGENCY CONTACT INFORMATION

Name_____ Relationship to patient_____

Phone numbers: Home (_____)_____ Cell (_____)_____ Work (_____)_____ext_____

REFERRED BY Name_____ ☐Physician ☐Family/Friend ☐Provider Directory ☐Internet/Website ☐Phone Directory

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 deductible, 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 of patient or legal guardian_____ DATE _____