



We want you well.

Welcome to Esse Health!

At Esse Health, we are dedicated to patient satisfaction, service and value. Our Mission is to place you and your physician at the center of every health care decision. We know your choice of a physician is an important decision, and we are committed to providing the highest quality care by working with you to maximize your health. We call it patient-centered care.

What does patient-centered care mean for you? It means you have a team of health care professionals, led by your physician, who can help you be more involved in your health care and take better care of yourself. It means you have access to resources like our Patient Portal that allows you to ask a medical question, request an appointment or refill a medication at times that are convenient for you. And it means we provide the highest quality care in the most cost effective way.

Thank you for choosing Esse Health as your partner in healthcare. We are committed to you and your family's good health.

Best Wishes,

Dave Kearney
Chief Executive Officer
Esse Health



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

I authorize the use or disclosure of the above-named individual’s health information as described below.

INFORMATION TO BE RELEASED BY:

INFORMATION TO BE RELEASED TO:

Organization/Person Name

Organization/Person Name

Address City, State, Zip

Address City, State, Zip

TYPE OF MEDICAL INFORMATION TO BE DISCLOSED

- Complete Medical Record
- List of Allergies
- X-ray reports
- Physician Progress Notes
- Problem list
- EKG
- Immunization Records
- Lab Reports
- Medication list
- Consultation Reports
- Other (please specify) _____
- My health information relating only to the following treatment/condition _____
- My health information only for the following dates: _____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It also may include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby **specifically authorized to release** all information or medical records relating to such diagnosis, testing or treatment, unless specifically excluded below.

I understand I have a right to cancel this authorization at any time. I understand if I wish to withdraw this authorization, I must do so in writing. I must present my written cancellation to the health information management department. I understand the authorization withdrawal will not apply to information that has already been released due to this authorization. I understand the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise cancelled, this authorization will expire on the following date or event _____. If I fail to specify an expiration date or event, this authorization will expire in six months.

I understand authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I do not have to sign this form to receive treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand any disclosure of information carries with it the possibility for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact my physician’s office manager. I understand there may be a charge associated with copying my health information.

Signature of Patient/Legal Representative

Date



Patient Name: _____ Date of Birth: _____

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 numbers:

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 _____

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: _____



We want you well.

ADULT REGISTRATION/UPDATE FORM

PATIENT INFORMATION

TODAY'S DATE _____

Last Name		First Name		Middle Initial	
Home Phone		Work Phone		Cell Phone	
E-mail Address		Date of Birth		Age	
Home Address	Street	City	State	Zip	
Occupation		Employer Name		Zip	
Employer Address	Street	City	State		
Birth Sex	<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> None	<input type="checkbox"/> Undifferentiated	<input type="checkbox"/> Unknown
Current Gender	<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> None	<input type="checkbox"/> Undifferentiated	
Gender Identity	<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> Genderqueer/Non-Binary	<input type="checkbox"/> Choose Not to Disclose	
	<input type="checkbox"/> Female-to-Male (FTM)	<input type="checkbox"/> Male-to-Female (MTF)	<input type="checkbox"/> Neither Exclusively Male or Female		<input type="checkbox"/> Additional Gender Category or Other Please Specify
	<input type="checkbox"/> Transgender Male/Trans Man	<input type="checkbox"/> Transgender Female/Trans Woman			
Sexual Orientation	<input type="checkbox"/> Straight or Heterosexual	<input type="checkbox"/> Lesbian, Gay or Homosexual	<input type="checkbox"/> Bisexual	<input type="checkbox"/> None	
	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Something Else, Please Describe	<input type="checkbox"/> Choose Not to Disclose		
Preferred Pronoun	<input type="checkbox"/> She, Her, Hers	<input type="checkbox"/> He, Him, His	<input type="checkbox"/> They, Them, Theirs	<input type="checkbox"/> Ze, Hir	
	<input type="checkbox"/> Other	<input type="checkbox"/> None	<input type="checkbox"/> Asked, but Unknown	<input type="checkbox"/> Decline to Answer	
Marital Status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Legally Separated	
	<input type="checkbox"/> Annulled	<input type="checkbox"/> Widowed	<input type="checkbox"/> Interlocutory	<input type="checkbox"/> Life Partner	
	<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Polygamous	<input type="checkbox"/> Unknown		

HEALTH INSURANCE INFORMATION

MUST BE COMPLETED FOR ESSE HEALTH TO BILL YOUR INSURANCE COMPANY

PRIMARY INSURANCE		SECONDARY INSURANCE	
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	_____	Date Insurance Began	_____
[] HMO [] PPO [] OTHER	_____	[] HMO [] PPO [] OTHER	_____
COPAY	_____	COPAY	_____

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

Last Name	First Name	Middle Initial	Relationship to Patient		
Home Phone	Work Phone		Cell Phone		
E-mail Address	Date of Birth		Age		
Home Address	Street	City	State	Zip	
Occupation		Employer Name			
Employer Address	Street	City	State	Zip	



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 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 _____

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 _____ |



PATIENT INFORMATION SHEET

TODAY'S DATE _____

Patient's	Last Name	First Name	Middle Initial
Home Phone		Work Phone	Cell Phone
E-mail Address		Date of Birth	Age
Home Address	Street	City	State Zip
Occupation		Employer Name	Zip
Employer Address	Street	City	State
Birth Sex	<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> None <input type="checkbox"/> Undifferentiated <input type="checkbox"/> Unknown
Current Gender	<input type="checkbox"/> Female	<input type="checkbox"/> Male	<input type="checkbox"/> None <input type="checkbox"/> Undifferentiated
Gender Identity	<input type="checkbox"/> Female <input type="checkbox"/> Female-to-Male (FTM) <input type="checkbox"/> Transgender Male/ <input type="checkbox"/> Trans Man	<input type="checkbox"/> Male <input type="checkbox"/> Male-to-Female (MTF) <input type="checkbox"/> Transgender Female/ <input type="checkbox"/> Trans Woman	<input type="checkbox"/> Genderqueer/Non-Binary <input type="checkbox"/> Neither Exclusively Male or Female <input type="checkbox"/> Choose Not to Disclose <input type="checkbox"/> Additional Gender Category or Other Please Specify
Sexual Orientation	<input type="checkbox"/> Straight or Heterosexual <input type="checkbox"/> Don't Know	<input type="checkbox"/> Lesbian, Gay or Homosexual <input type="checkbox"/> Something Else, Please Describe	<input type="checkbox"/> Bisexual <input type="checkbox"/> Choose Not to Disclose <input type="checkbox"/> None
Preferred Pronoun	<input type="checkbox"/> She, Her, Hers <input type="checkbox"/> Other	<input type="checkbox"/> He, Him, His <input type="checkbox"/> None	<input type="checkbox"/> They, Them, Theirs <input type="checkbox"/> Asked, but Unknown <input type="checkbox"/> Ze, Hir <input type="checkbox"/> Decline to Answer
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Annulled <input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Polygamous	<input type="checkbox"/> Divorced <input type="checkbox"/> Interlocutory <input type="checkbox"/> Unknown <input type="checkbox"/> Legally Separated <input type="checkbox"/> Life Partner

ADVANCED DIRECTIVES

Do you have: Durable Power of Attorney Living Will DNR (Do not Resuscitate) None of these

Please let us know if you would like more information on any of the above items.

Employer: _____ **Occupation:** _____ **Year Retired:** _____

MEDICATIONS & VITAMINS

Please list all of your medications, prescription and nonprescription, and the dosage amount:

Medications	Dosage, how taken
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	



PATIENT INFORMATION SHEET

Name: _____

Please list all vitamins, supplements and other over the counter products.

Vitamins/OTC	Dosage, how taken
1.	
2.	
3.	
4.	

Please list medication **ALLERGIES** or medications you cannot take. Check here if **NO** allergies.

1.	3.
2.	4.

PHARMACY INFORMATION

Preferred Pharmacy Name Pharmacy Phone Number Pharmacy Address

Alternative Pharmacy Name Pharmacy Phone Number Pharmacy Address

PAST MEDICAL HISTORY

Please place a check mark in the box if you have ever experienced any of the following conditions. Also, if you know the year, please include it.

	Year		Year		Year		Year
<input type="checkbox"/> Allergies		<input type="checkbox"/> Blood Clots		<input type="checkbox"/> Gallbladder Disease		<input type="checkbox"/> MI/Heart	
<input type="checkbox"/> Anemia		<input type="checkbox"/> Cancer		<input type="checkbox"/> Reflux/GERD		<input type="checkbox"/> Osteoarthritis	
<input type="checkbox"/> Angina		<input type="checkbox"/> CVA/Stroke		<input type="checkbox"/> Hepatitis C		<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Anxiety		<input type="checkbox"/> COPD/Lung		<input type="checkbox"/> High Cholesterol		<input type="checkbox"/> Peptic Ulcer	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Coronary Artery		<input type="checkbox"/> High Blood Pressure		<input type="checkbox"/> Kidney/Renal	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Crohn's Disease		<input type="checkbox"/> Irritable Bowels		<input type="checkbox"/> Seizures	
<input type="checkbox"/> Atrial Fibrillation		<input type="checkbox"/> Depression		<input type="checkbox"/> Liver Disease		<input type="checkbox"/> Thyroid	
<input type="checkbox"/> Benign Prostatic Hypertrophy		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Migraine Headaches		<input type="checkbox"/> Other	



PATIENT INFORMATION SHEET

Name: _____

PAST SURGICAL HISTORY

Please place a check mark in the box if you have ever had any of the following surgeries. Also, if you know the year, please include it.

	Year		Year		Year
<input type="checkbox"/> Angioplasty		<input type="checkbox"/> Cesarean Section		<input type="checkbox"/> Myomectomy	
<input type="checkbox"/> Angioplasty With Stent		<input type="checkbox"/> Colectomy (Colon Removed)		<input type="checkbox"/> ORIF/ Hip Fracture	
<input type="checkbox"/> Appendectomy		<input type="checkbox"/> Colostomy (Wear A Bag)		<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Arthroscopic Knee Surgery		<input type="checkbox"/> D and C		<input type="checkbox"/> Prostate Biopsy	
<input type="checkbox"/> Back Surgery		<input type="checkbox"/> Gastric Bypass		<input type="checkbox"/> Small Bowel Resection	
<input type="checkbox"/> Breast Biopsy		<input type="checkbox"/> Hernia Repair		<input type="checkbox"/> Thyroidectomy	
<input type="checkbox"/> Breast Augmentation		<input type="checkbox"/> Hip Replacement		<input type="checkbox"/> Tonsillectomy	
<input type="checkbox"/> Breast Reduction		<input type="checkbox"/> Hysterectomy		<input type="checkbox"/> Tubal Ligation	
<input type="checkbox"/> CABG/Bypass Surgery		<input type="checkbox"/> Knee Replacement		<input type="checkbox"/> TURP /Prostate Removal	
<input type="checkbox"/> Carpal Tunnel		<input type="checkbox"/> Lasik		<input type="checkbox"/> Vasectomy	
<input type="checkbox"/> Cataract		<input type="checkbox"/> Liver Biopsy		<input type="checkbox"/> Other:	
<input type="checkbox"/> Cholecystectomy (Gallbladder)		<input type="checkbox"/> Mastectomy		<input type="checkbox"/>	

PAST DIAGNOSTICS

Please place a check mark in the box if you have ever had any of the following tests or procedures. Please include the approximate date the procedure was completed and the results, if known.

	Approximate Date	Results (if known)		Approximate Date	Results (if known)
<input type="checkbox"/> Colonoscopy			<input type="checkbox"/> Eye Exam		
<input type="checkbox"/> Sigmoidoscopy			<input type="checkbox"/> Dental Exam		
<input type="checkbox"/> Echocardiogram			<input type="checkbox"/> PPD		
<input type="checkbox"/> Cardiac Stress Test			<input type="checkbox"/> Pulmonary Function Test		
<input type="checkbox"/> Cardiac Catheterization			<input type="checkbox"/> Bone Density/ Dexa Scan		
<input type="checkbox"/> Holter Monitor			<input type="checkbox"/> Diabetes Test		
<input type="checkbox"/> Lipid Panel			<input type="checkbox"/> Hepatitis C Test		
<input type="checkbox"/> Mammogram			<input type="checkbox"/> Last Pap Smear		



PATIENT INFORMATION SHEET

Name: _____

FAMILY HISTORY

Please check if any family member has ever had any of the following conditions. Include information even if the person is deceased.
Please check here if you are adopted.

	Mother	Father	Sister	Brother	Grandparents	Other
ADD/ADHD						
Alcoholism						
Allergies						
Alzheimer's Disease						
Asthma						
Blood Disease						
CAD / Heart Disease						
Heart Disease Before Age 50						
Cancer :Type						
Cancer: Type						
CVA /Stroke						
Depression						
Diabetes						
Eczema						
Hearing Deficiency						
High Cholesterol/Hyperlipidemia						
High Blood Pressure /Hypertension						
Irritable Bowel Disease						
Learning Disability						
Mental Illness						
Migraines						
Obesity						
Osteoarthritis						
Osteoporosis						
Peripheral Vascular Disease/PVD						
Renal/Kidney Disease						
Seizures/Epilepsy						
Other:						

SOCIAL HISTORY & HEALTH MAINTENANCE

Do you use tobacco? No Yes Former Type of tobacco used? _____

Packs per day if cigarettes? _____ Years smoked? _____ Date Quit? _____

Other tobacco (cans, cigars) per day? _____ Years smoked? _____ Date Quit? _____

Do you drink alcohol? Currently Never Former Date Quit? _____

Type of alcohol? _____ Daily amount? _____ How often? _____

Vaccine:	Date of Last Vaccine:	Vaccine:	Date of Last Vaccine:
<input type="checkbox"/> Hepatitis A	1 st : _____ / 2 nd : _____	<input type="checkbox"/> Meningococcal	
<input type="checkbox"/> Hepatitis B (3 shot series)	1 st : _____ / 2 nd : _____ / 3 rd : _____	<input type="checkbox"/> Pneumococcal	
<input type="checkbox"/> HPV/Gardasil	1 st : _____ / 2 nd : _____ / 3 rd : _____	<input type="checkbox"/> Tetanus	
<input type="checkbox"/> Influenza		<input type="checkbox"/> Varicella/Chicken Pox (childhood)	
<input type="checkbox"/> Measles/Mumps/Rubella		<input type="checkbox"/> Herpes Zoster (adult)	



We want you well.

PATIENT INFORMATION SHEET

Name: _____

Please check the box if you are currently experiencing any of the following:

General

- Chills
- Fatigue/Tiredness
- Fever
- Feel Lousy/Malaise
- Night Sweats
- Weight Gain
- Weight Loss

Eyes, Ears, Nose & Throat

- Ear Drainage
- Ear Pain
- Eye Discharge
- Eye Pain
- Hearing Loss
- Nasal Drainage
- Sinus Pressure
- Sore Throat
- Visual Changes

Respiratory/Lung

- Chronic Cough
- Cough
- TB Exposure
- Shortness of Breath
- Wheezing

Cardiovascular/Heart

- Chest Pain
- Calf Pain with Walking/Claudication
- Swelling, Fluid Retention/Edema
- Heart Racing/Palpitations

Gastrointestinal/GI

- Abdominal Pain
- Blood in Stools
- Change in Stools
- Constipation
- Diarrhea
- Heartburn
- Loss of Appetite
- Nausea
- Vomiting

Urinary

- Dribbling
- Dysuria/Pain on Urination
- Hematuria /Blood in Urine
- Polyuria/Excessive Urination
- Slow Stream
- Urinary Frequency
- Urinary Incontinence
- Urinary Retention

Circulation

- Blood Clots/Thrombophlebitis
- Ulcer of the Feet or Legs

Female Reproductive

- Abnormal Pap
- Breast Discharge
- Breast Lump
- Dysmenorrhea/Painful Periods
- Dyspareunia/Painful Sex
- Hot Flashes
- Irregular Menses (Period)
- Vaginal Discharge
- LMP(Period): _____

Metabolic/Endocrine

- Brittle Hair
- Brittle Nails
- Cold Intolerance
- Hair Changes
- Heat Intolerance
- Hirsutism/Excessive Facial Hair
- Polydipsia/ Excessive Thirst
- Polyphagia/ Excessive Eating

Neurological

- Dizziness
- Extremity Numbness
- Extremity Weakness
- Gait Disturbance/Difficulty Walking
- Headache
- Memory Loss
- Seizures
- Tremors

Mood

- Anxiety
- Depression
- Insomnia

Skin

- Contact Allergy
- Hives
- Itching
- Mole Changes
- Rash
- Skin Lesion

Musculoskeletal

- Back Pain
- Joint Pain
- Joint Swelling
- Muscle Weakness
- Neck Pain

Hematologic/Blood

- Easy Bleeding
- Easy Bruising
- Lymphadenopathy/Enlarged Lymph Nodes

Allergies

- Environmental Allergies
- Food Allergies
- Seasonal Allergies

Male Reproductive

- Erectile Dysfunction/ED
- Penile Discharge
- Sexual Dysfunction

Other

- _____
- _____
- _____
- _____

Patient/Parent/Care Giver Signature

Date

Date: _____



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
- Decline to Specify
- Other Race

PREFERRED LANGUAGE

- English
- Spanish
- Bosnian
- Russian
- Italian
- French
- German
- Chinese
- Japanese
- Central Khme
- Haitian; Haitian Creole
- Hebrew
- Portuguese
- Korean
- Somali
- Arabic
- Spanish Castilian
- Vietnamese
- Hindi
- Polish
- Thai
- Other
- Bulgarian
- Urdu
- Swahili
- Decline to Specify

ETHNICITY

- Hispanic or Latino
- Not Hispanic or Latino
- Decline to Specify

CONTACT PREFERENCE

- Cell Phone
- Confidential
- Email/Portal
- Home Phone
- Mail
- Work Phone
- Decline to Specify