akane institute
FEEL BETTER Live Your Life!
ALLERGY ASTHMA SLEEP MEDICINE

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FEEL BETTER Live Your Life!
BEHAVIORAL MEDICINE
Child • Adolescent • Adult Psychiatry

NEW PATIENT REGISTRATION FORM

1. **Patient name:** _____
2. **Date of Birth:** _____
3. **Social Security Number:** _____
4. **Address**_____**Zip Code**_____
5. **Home phone** _____**Cell Phone**_____**Work Phone**_____
6. **Preferred pharmacy** _____ **Phone**_____
7. **Race:**
   □ **Caucasian** □ **American Indian** □ **Asian** □ **African American** □ **Pacific Islander**
8. **Ethnicity:**
   □ **Hispanic/Latino** □ **Other** _____
9. **Preferred Language:** □ **English** □ **Spanish** □ **Other** _____
10. **Marital Status:**
    □ **Married** □ **Divorced** □ **Separated** □ **Single** □ **Widow**
11. **Emergency Contact (living with you)**
    Name: _____
    Phone #: _____ **Relationship:** _____
12. **Emergency Contact (NOT living with you)**
    Name: _____
    Phone #: _____ **Relationship:** _____
13. **If insured party is different from the patient, please provide the following:**
    a. **Name:** _____ **DOB:** _____
    b. **Relationship:** _____ **SSN:** _____
    c. **Address:** _____
    d. **Phone Number:** _____

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