Akwaaba Care
FAMILY PRACTICE

1450 East Street
Suite Seven
Pittsfield, MA 01201
ph 413.728.9801
fax 833.989.2283

New Patient Registration Form

Please Fill Out Each Section Completely

today's date is____________

Name (First, MI, Last)____

Date of Birth _____/_____/_____ Age:________ Legal Sex: M F Preferred Pronouns__________

Mailing Address____

____

Physical Address if different from Mailing____

____

Mobile Phone (_________)___________________ Home Phone (__________)________________

Other Phone (_________)____________________ Work Phone (__________)_________________

SS#____________________Primary Email Address____

Employer Name and Address____

____

Employer Phone Number (________)_____________________________

Work Email Address____

Would you like to activate your patient portal? Yes No

Demographic information: Race/Ethnicity________________Country of Origin____________

Primary Language spoken, if not English____

Marital Status:☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse Name (First, MI, Last)____

Spouse Address, if different from above____

Spouse Mobile Phone(_________)___________________

Other family members that are patients:____

How did you hear about us? ____

____

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Primary Health Insurance Company_______________________________________
Member ID number_______________ Policy number________________________
Group number____________ Product type (HMO, PPO, etc)__________________
Effective date_______________ Annual Deductible__________________________

Secondary Health Insurance____
Member ID number____________ Policy number___________________________
Group number_______________ Effective date______________________________
Product type______________Annual Deductible_____________________________

Policy Holder, circle one: Self Spouse Parent ▫Child
Name of Policy Holder, if not Self____
Policy Holder information
Date of Birth _____/_____/_____ Age _____ Sex M F
Mobile phone(_________)_____________SS #_________________________________
Home Address____
____

Please circle Y or N next to each statement

I am a student: Y N

I am a homemaker: Y N

I am retired: Y N

I am unemployed: Y N

I am collecting unemployment: Y N

I am legally disabled with SSI benefits: Y N

I am a working-aged Medicare Beneficiary due to a disability diagnosis: Y N

I am currently receiving temporary financial assistance: Y N

I am currently receiving SNAP benefits: Y N

I would or do qualify for a financial hardship determination: Y N

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Emergency Contact (Please list someone who does not live with you)
Name______________________________Relationship to patient ______________________
Phone number (_______)______________________________
Address____

Name of preferred pharmacy____
Address____
Phone number (_________)________________________

Previous Primary Care Provider____
Practice Name____
Release of Medical Records form completed: Y N

Please include anything else that you would like us to know about you or your healthcare goals. We are looking forward to getting to know you!
____
____
____
____
____
____
____

I hereby certify that the above is true to the best of my knowledge.

Signed______________________________
Date________________________
Printed name_____________________________________