alo·ha psych ASSOCIATES, INC.

PATIENT REGISTRATION - ADULT

IDENTIFYING INFORMATION:

Name	Occupation	M F	Date of Birth	Age
Preferred: e-mail				
Home Address				
City	State		Zip	
Preferred Contact Numbers: Home phone:	Work Phone:		Cell Phone:	

FAMILY INFORMATION:

Marital Status:
Spouse/Partner/Significant Other's:

Name:	Employer:	Best phone number:

EMERGENCY CONTACTS (2):

Name	Phone Number	Address

PRIMARY INSURANCE COMPANY:

Name		Phone Number
Group Number	ID Number	
Subscriber's Name	Subscriber's Birth Date	Social Security #

SECONDARY INSURANCE COMPANY:

Name		Phone Number
Group Number	ID Number	
Subscriber's Name	Subscriber's Birth Date	Social Security #

- **My signature on this form authorizes contact with my Primary Care Provider.**
- **My signature on this form authorizes the release of medical information necessary to process this claim for my insurance.**
- **My signature on this form authorizes payment of insurance benefits to my treating provider and acknowledgment that co-payments are expected at the time of the visit.**

_____ _____

SIGNATURE **DATE**