



## Howard Askins, M.D., J.D.

Psychiatry for Adolescents, Adults & Geriatrics

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### Patient Registration Sheet

#### Patient Data

Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_ SSN: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender: M/F Martial Status \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone Number \_\_\_\_\_ ok to call Yes/No Cell Number \_\_\_\_\_

Employer / School \_\_\_\_\_ Occupation \_\_\_\_\_

Work / School Phone Number \_\_\_\_\_ ok to call Yes / No

Emergency Contact \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Phone Number \_\_\_\_\_

#### Parent / Guardian Information

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN: \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

#### Insurance Data

Insurance Name \_\_\_\_\_ Policy Number \_\_\_\_\_

Group Number \_\_\_\_\_ Subscriber's Name \_\_\_\_\_

Subscriber's SSN \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_

Subscriber's Relationship to Patient \_\_\_\_\_ Insurance Phone Number \_\_\_\_\_

Secondary Insurance Name \_\_\_\_\_ Policy Number \_\_\_\_\_

Group Number \_\_\_\_\_ Subscriber's Name \_\_\_\_\_

Subscriber's SSN \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_

Subscriber's Relationship to Patient \_\_\_\_\_ Insurance Phone Number \_\_\_\_\_

**Medical History**

Primary Care Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Authorization to Release Information to Primary Care Physician Yes / No

Signature \_\_\_\_\_

Current Medical Conditions \_\_\_\_\_

Current Prescribed Medication \_\_\_\_\_

\_\_\_\_\_

Reason for Seeking Treatment \_\_\_\_\_

\_\_\_\_\_

Allergies \_\_\_\_\_