ALANA SASAKI, M.D.
KAI SHIN CLINIC

777 Raymond Ave, St Paul, MN 55113 Phone: (651) 447-3755 Fax: (651) 444-8923

NEW PATIENT REGISTRATION Date: _______________

Name: ___________________________ Birth date: __________

Address: ___________________________

____

Contacts: Messages Okay? Limitations

Home Telephone: ______________________ yes/no

Work Telephone: ______________________ yes/no

Cellular Phone: _______________________ yes/no

Email: _______________________________ yes/no

Emergency Contact: __________________ yes/no

Phone: ___________________

Pharmacy: __________________________ Address: ___________________

Phone: _______________________ ___________________

Fax: _________________________

Primary Care Provider(s):

Name: _________________________ Phone: __________________

Address: _______________________ Recent Complete Physical exam?

Name: _________________________ Phone: __________________

Address: _______________________

Mental Health Care Provider(s):

Name:_________________________ Phone: __________________

Address: _______________________

Addiction History (substance, amount, and length of use, any periods of sobriety?)

1. Substance used- amount length of use
2.
3.
4.

Chemical dependency treatments (please list when and where?) Was it successful, how long were you able to maintain sobriety?

Current groups or outpatient treatment?

What are your goals during your meeting and treatment with Dr Sasaki?

Insurance Company(ies):

Name: ___________________________

Id: ________________________ Group:______________

Household Members (animals included): Relationship

Current Prescription Medications (include dose and # of times taken):

Current Over-the-Counter Medications:

Current supplements/Vitamins/Herbs:

Allergies-Please describe substances, reactions and approximate dates of occurrence

Medication(s)

Environmental

Ongoing Medical Conditions:

List Past Medical Conditions:

I have received and reviewed the following documents and my questions if any have been answered to my satisfaction.

- ☐ **PRACTICE DESCRIPTION/EXPECTATIONS**
- ☐ **CLIENT RIGHTS/HIPPA**
- ☐ **SUBOXONE CONTRACT**
- ☐ ________________________________

SIGNATURE: