Murat Akalin, MD

Board Certified in Psychiatry and Family Medicine

Patient Information & Registration Form

Today's Date:_____

Name:_____ Date of Birth:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Phone 1 (Cell):_____ Phone 2:_____

Can a message be left at Phone 1? ☐ Yes ☐ No Can a message be left at Phone 2? ☐ Yes ☐ No

Email address:_____ May we email you? ☐ Yes ☐ No

Please note: email correspondence and text messaging are not considered to be a confidential mode of communication.

Marital Status: ☐ Never Married ☐ Domestic Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please list any children (names/ages): _____

Referred by (if any): _____

EMPLOYMENT INFORMATION

Present Employer:_____ Length Employed:_____

Title or Occupation:_____

MEDICAL/EMERGENCY INFORMATION

Primary Care Physician:_____ Phone:_____

Emergency Contact:_____ Phone:_____

If you would like to make payments using a debit/credit card, please complete the information below:

AUTHORIZATION TO BILL CREDIT CARD and RELEASE OF INFORMATION

The undersigned hereby instructs:

Name of Bank or Credit Card Company:_____

Credit Card Number:_____

Expiration Date:_____ VOC (3-digit code from back of card):_____

Name and Address associated with credit card (if different from above):

_____

...bank named above to send the payment directly to:

Murat Z. Akalin, MD
P.O. Box 1765
San Luis Obispo, CA 93406

_____ _____

Signature Date Print Name