KAREWELL MD PATIENT CARE

CHABOT FAMILY ASSOCIATES, INC.
20130 LAKE CHABOT RD, #202
CASTRO VALLEY, CA, 94546
PH: 510-582-6424 FAX: 510-582-6462

Patient Registration Form

Please Provide Copy of Your Insurance and STATE Issued Identification Card

Patient's Name (Last, First, MI): _____

Patient's Home Phone Number: _____ Alternate Phone Number (☐ cell or ☐ work): _____

E-Mail Address: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ SEX:_____ Social Security Number: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Patient's Employer: _____

Employment Status: ☐ Full time ☐ Part time ☐ Self Employed ☐ Retired ☐ Student ☐ Other: _____

Emergency Contact: _____ Relationship to Patient: _____

Address: _____ PHONE NO _____

INSURANCE INFORMATION

Primary Insurance: _____
Primary Insurance ID : _____
Primary Insurance Group NO: _____
Primary Insurance Effective Date : _____
Patient is Subscriber/Policy Holder: ☐

Secondary Insurance: _____
Secondary Insurance ID : _____
Secondary Insurance Group NO: _____
Secondary Insurance Effective Date : _____
Patient is Subscriber/Policy Holder: ☐

Please Provide Any Additional Insurance the Patient Has (Ex. Auto Insurance, Workers Comp or any Tertiary Insurance).
Should this Insurance be billed instead of the primary insurance listed above:

Insurance Name: _____
Type of Insurance: _____
Insurance ID / Group No : _____
Insurance Effective Date : _____
Insurance Address : _____
_____
Additional Contact Details : -_____
Insurance Contact No : _____

Continued ….

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PRIMARY INSURED INFORMATION (IF OTHER THAN PATIENT)

Subscriber/ Policy Holder: _____

Relationship to Patient : _____

Address: _____

Date of Birth: _____ SEX : _____

His or Her Employer: _____ Work Phone Number: _____

Home Phone Number: _____ Cell Phone Number : _____

Email ID : _____

RESPONSIBLE Party (Only Fill if other then Patient)

☐ **PATIENT** ☐ **PRIMARY INSURARED** ☐ **OTHER (PLEASE PROVIDE DETAILS BELOW)**

Responsible Party : _____

Relationship to Patient : _____ SEX : _____

Address: _____

His or Her Employer: _____ Work Phone Number: _____

Home Phone Number : _____ Cell Phone Number : _____

Email ID : _____

SIGNRATURE of Responsible Party : _____ DATE : _____

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above-named patient.

Name(s): _____
Relationship to Patient: _____

Chabot Family Associates reserves the right to charge a fee for any scheduled visits that are:

1. **Cancelled with less than 24 hour's notice for weekday clinics, and less then 48 hour's notice for Saturday Clinic's**
2. **Are missed without calling to cancel (no show)**

Cancellation Fee schedule: New Patient $40.00; Established Patient: $20.00

Patient / Parent or Guardian Signature: _____

Date: _____

Relationship to Patient: _____