



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: _____ SSN (Last 4 digits): _XXX-XX-_____

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



CHABOT FAMILY ASSOCIATES, INC.
19845 LAKE CHABOT ROAD, #205
CASTRO VALLEY, CA, 94546
PH: 510-582-6424 FAX: 510-582-6462

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 : \$30.00

Patient / Parent or Guardian Signature: _____

Date: _____

Relationship to Patient: _____

How did you hear about us (Website , Referred by): _____