Medical Offices of Dr. Shashwati S. Kale, M.D.
Family Medicine
2690 South White Road, #200, San Jose CA 95148
Phone: 408-223-8228

Patient Registration Form

Patient Information

Patient Name (Last, First, Middle) _____Birthday (MM/DD/YYYY) _____ Sex (M/F) __
Social Security Number ____-____-_____ Marital Status (Married/Single/Divorced/other) ____
Email: _____ Home Phone: _____Mobile Phone: _____ Work Phone _____
Street Address: _____ City _____ State_____ Zip _____
Occupation _____ Employer _____ Phone _____
Employer Street Address: _____ City _____ State_____ Zip _____

Primary Insurance Information

Subscriber Name: (Last, First, Middle) _____ Birthday (MM/DD/YYYY) _____
Relationship to patient _____ Subscriber Social Security _____
Occupation _____ Employer _____ Work Phone _____
Employer Street Address: _____ City _____ State_____ Zip _____
Insurance Company _____ ID number _____ Group Number _____ Co-pay $ _____
Insurance Street Address: _____ City _____ State_____ Zip _____

Secondary Insurance Information

Subscriber Name: (Last, First, Middle) _____ Birthday (MM/DD/YYYY) _____
Relationship to patient _____ Subscriber Social Security _____
Occupation _____ Employer _____ Work Phone _____
Employer Street Address: _____ City _____ State_____ Zip _____
Insurance Company _____ ID number _____ Group Number _____ Co-pay $ _____
Insurance Street Address: _____ City _____ State_____ Zip _____

Emergency Contact

Contact Name: (Last, First, Middle) _____ Phone Home_____ Phone Mobile _____
Relationship to patient _____
Contact Street Address: _____ City _____ State_____ Zip _____

Authorization

The patient is under the care and supervision of his/her attending physician and it it the responsibility of the clinic and its nursing staff to carry out instructions of such physician. In accordance with California Law, I herby consent to and authorize the administration of all medical diagnostic procedures, medical treatments, anesthetics, X-rays examination and surgical procedures deemed necessary by the attending physician for the patient named in this document . In addition, I authorize the release of any medical or any other information necessary to process this claim I also request payment of government benefits to the party who accepts assignment. I authorize payment f medical benefits to the undersigned physician or supplier for services described.

Patient/Guardian Signature _____ Date _____