WELCH PASTEUR ALLERGY MEDICAL GROUP, INC

DR. CHOY/ DR. MAK

211 QUARRY ROAD, SUITE 106 MAIL CODE 5996 PALO ALTO, CA 94304

PATIENT REGISTRATION FORM

Date_______________
First Name____________________Last____________________Middle_______________DOB______________
Martial Status: Single____ Married____ Widowed____ Divorced____ Separated____
Street Address____
City______________________________________State_____________Zip Code_______________________
Phone # Home(______)________________Work(______)________________Cell(______)___________________
Email Address____
Occupation___________________________________Employer______________________________________
SS#_______-______-_________ Driver's License #__________________Referred By____________________
Spouse Name____DOB___________________________
Occupation___________________________________Employer______________________________________
If under 18 (Parent/Guardian)____
Emergency Contact (Other than Spouse) Name__________________________Relation_______________
Address____Phone # (______)_____________________

INSURANCE & BILLING INFORMATION

PRIMARY INSURANCE
Name of Policy Holder____________________________ SS#_______-_____-_______DOB_______________
(If other than Patient) Name of Insurance____
Group #____________________________________ Member ID #_________________________________
Name of Employer______________________________Address__________________________________
Position____Work Phone (_______)_________________________

OTHER INSURANCE (IF ANY)
Name of Policy Holder____________________________ SS#_______-_____-_______DOB_______________
(If other than Patient) Name of Insurance____
Group #____________________________________ Member ID #_________________________________
Name of Employer______________________________Address__________________________________
Position____Work Phone (_____)_____________________

ASSIGNMENT OF INSURANCE BENEFITS

I here by authorize direct payment of surgical/medical benefits to Dr. _________________ for services rendered by him/her in person under his/her supervisor. I understand that I am financially responsible for any balance not covered by my insurance.

MEDICARE

I certify that the information given by me in applying for payments is correct. I request that payment of authorized benefits be made on my behalf.

CONSENT TO MEDICAL TREATMENT AND ALLERGY TESTING

I authorize the Doctors at the Welch Pasteur Allergy Medical Group, Inc to undertake appropriate investigation and to give me treatment deemed medically reasonable.

Patient Name (Please Print)__________________________Signature_______________________
Parent/Guardian (Please Print)______________________________Date____________________