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

Today's Date_____
First Name_____Last_____Middle_____DOB_____
Martial Status: Single____ Married____ Widowed____ Divorced____ Separated____
Race: Asian__ African American__ Hispanic__ Native American__ Caucasian__ Other:_____
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_____