

**SOUTH BAY ALLERGY AND ASTHMA GROUP, INC.**

**PATIENT REGISTRATION FORM**

Theodore J. Chu, M.D.

130 Bellerose Drive (main office)

2505 Samaritan Dr.

2500 Hospital Dr.

Anlin Xu, M.D.

San Jose CA 95128

Ste. 407

Bldg. 10

John S. Kellogg, M.D., M.S.

408 286-1707

San Jose CA 95124

Mt. View CA 94040

Jimmy Ko, M.D.

www.sbaag.com

408 358-1771

650 966-8201

**PATIENT INFORMATION**

Last Name \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_  
First name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_ Social Security # \_\_\_\_\_  
City, State Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_  
Address \_\_\_\_\_ Referring Doctor \_\_\_\_\_  
City, State Zip \_\_\_\_\_ Address \_\_\_\_\_  
City, State Zip \_\_\_\_\_ Address \_\_\_\_\_  
**Is any family member a patient?** Yes  No  City, State Zip \_\_\_\_\_

**Name of family member** \_\_\_\_\_

**RESPONSIBLE PARTY**

Last Name \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_  
First name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_ Social Security # \_\_\_\_\_  
City, State Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address \_\_\_\_\_  
City, State Zip \_\_\_\_\_  
For Office Use only  
Account# \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance** \_\_\_\_\_ Policy Owner/Subscriber \_\_\_\_\_  
Address \_\_\_\_\_ Insured Policy ID \_\_\_\_\_  
City, State Zip \_\_\_\_\_ Group # \_\_\_\_\_  
Telephone \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Effective Dates \_\_\_\_\_ Patient Relation to Owner \_\_\_\_\_  
Copay Amount \_\_\_\_\_

**Second Insurance** \_\_\_\_\_ Policy Owner/Subscriber \_\_\_\_\_  
Address \_\_\_\_\_ Insured Policy ID \_\_\_\_\_  
City, State Zip \_\_\_\_\_ Group # \_\_\_\_\_  
Telephone \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Effective Dates \_\_\_\_\_ Patient Relation to Owner \_\_\_\_\_  
Copay Amount \_\_\_\_\_

**PERSON TO CONTACT IN CASE OF EMERGENCY**

Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Relation to Patient \_\_\_\_\_ Work Phone \_\_\_\_\_  
Mobile Phone or Pager \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize South Bay Allergy and Asthma Group, Inc. to release any information necessary to process insurance claims relating to the medical care rendered by South Bay Allergy and Asthma Group, Inc.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**ASSIGNMENT OF MEDICAL BENEFITS**

I authorize payments of medical benefits to SOUTH BAY ALLERGY AND ASTHMA GROUP, INC. for any medical care rendered to myself or to my dependents. I understand that I am responsible for any amount not covered by my insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_