Theodore J. Chu, MD, Allergy and Asthma, Inc.; Alan M. Heller, MD, Inc.

Practice Limited to Allergic Diseases and Asthma in Children and Adults

130 Bellerose Drive • San Jose, CA 95128 • T (408) 816-8923 • F (669) 242-7914 • www.chuallergy.com

Patient Information

Patient full name: ______________________

DOB: __________ SSN: ______________

Address: ______________________

City: ______________________

State: __________ Zip code: ______________

Home phone: (_______) ______________

Cell phone: (_______) ______________

Work phone: (_______) ______________

Occupation: ______________________

Employer's name: ______________________

Work address: ______________________

City: ______________________

State: __________ Zip code: ______________

Email address: ______________________

Preferred method of contact: ______________

If patient is a minor, parent's full name: ______________

Please list other family members that are patients and relationship: ______________________

Referral

How did you hear about us? ______________

If applicable:

Referring physician name: ______________

Referring physician phone number: (_____) ______________

Referring physician address: ______________

____

City: ______________________

State: __________ Zip code: ______________

Insurance Information

Insurance carrier: ______________________

ID #: ______________________

Group number: ______________________

Insurance address: ______________________

City: ______________________

State: __________ Zip code: ______________

Check here if self-pay: ☐

Guarantor: ______________________

Guarantor address: ______________________

City: ______________________

State: __________ Zip code: ______________

Guarantor DOB: ______________________

Emergency Contacts

Name #1: ______________________

Phone number: ______________________

Alternate number: ______________________

Relationship to patient: ______________________

Name #2: ______________________

Phone number: ______________________

Alternate number: ______________________

Relationship to patient: ______________________

Authorization to Release Information

I hereby authorize Theodore J. Chu, MD, Allergy and Asthma, Inc., to release any information necessary to process insurance claims relating to the medical care rendered by Theodore J. Chu, MD, Allergy and Asthma, Inc.

Assignment of Medical Benefits

I authorize payments of medical benefits Theodore J. Chu, MD, Allergy and Asthma, 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.

Consent to treatment of myself or a minor or dependent

I consent and authorize routine and emergency medical treatment for me/my child/my dependent (circle one) when deemed necessary by authorized personnel including doctors at Theodore J. Chu, MD, Allergy and Asthma, Inc. this authorization will remain effective unless revoked in writing by me.

Name: ______________________

Signed: ______________________

Date: ______________________