# Patient Registration Information

***Please PRINT AND complete ALL sections below***

**JOHN C. CHIU, M.D.**
FAMILY PRACTICE
100 LOS GATOS SARATOGA ROAD, SUITE B
LOS GATOS, CA 95032
(408) 863-0709

**Office use only**

Date: ____________________________________________

Account No: ____________________________________________

Insurance Co: ____________________________________________

Co-Payment: $ ____________________________________________

Insurance cards copied ❑ Credit Card Authorizaion ❑

Is your condition a result of a work injury? ❑Yes ❑No

Date of injury: ________________________

An auto accident? ❑Yes ❑No

## PATIENT'S PERSONAL INFORMATION

Last Name: ________________________________________ First Name: ________________________ Middle Initial: _________

Address (Street): ______________________________________________________________________________________

(City, State, ZIP): ______________________________________________________________________________________

Home phone: ________________________ Work phone: ________________________ Social Security: ______________________

Date of Birth: _________________________ Driver's License (State & Number): ________________________________________

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed Sex: ❑Male ❑Female

Employer / Name of School ____________________________________________________________ ❑Full Time ❑Part Time

Address (Street): ______________________________________________________________________________________

(City, State, ZIP): ______________________________________________________________________________________

Your occupation: ______________________________________________________________________________________

Spouse's Name: _______________________________________________ Spouse's Work phone: _________________________

How do you wish to be addressed? _____________________________________________________________________

## PATIENT'S / RESPONSIBLE PARTY INFORMATION

Responsible party: ______________________________________________________ Date of Birth: _________________________

Relationship to Patient: ❑Self ❑Spouse ❑Other _________________________ Social Security: _________________________

Responsible party's Home phone: _________________________ Work phone: _________________________

Address (Street): ______________________________________________________________________________________

(City, State, ZIP): ______________________________________________________________________________________

Spouse's Employer's name: ________________________________________ Spouse's Work phone: ________________________

Address (Street): ______________________________________________________________________________________

(City, State, ZIP): ______________________________________________________________________________________

## PATIENT'S INSURANCE INFORMATION    Please present insurance cards to receptionist

PRIMARY insurance company's name: ______________________________________________

Insurance Address (Street): ______________________________________________

(City, State, ZIP): ______________________________________________

Name of insured: ______________________________ Date of Birth: ____________

Relationship to insured: ❑Self ❑Spouse ❑Child ❑Other

Insurance ID number: ____________________ Group number: ____________________

SECONDARY insurance company's name: ______________________________________________

Insurance Address (Street): ______________________________________________

(City, State, ZIP): ______________________________________________

Name of insured: ______________________________ Date of Birth: ____________

Relationship to insured: ❑Self ❑Spouse ❑Child ❑Other

Insurance ID number: ____________________ Group number: ____________________

Check if appropriate: ❑ Medigap policy ❑ Retiree coverage

## PATIENT'S REFERRAL INFORMATION

Referred by: ______________________ If referred by a friend, may we thank her or him? ❑YES ❑NO

Name(s) of other physician(s) who care for you______________________________________

## EMERGENCY CONTACT

Name of person not living with you: ______________________ Relationship: ____________

Address (Street): ______________________________________________

(City, State, ZIP): ______________________________________________

Home phone: ____________ Work phone: ____________

Assignment of Benefits ◆ Financial Agreement ◆ Appointment Policy

I hereby assign, transfer, and set over John C. Chiu, M.D. all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I give authorization for payment of insurance benefits to be made directly to John C. Chiu, M.D., and any assisting physicians, for services rendered. I authorize the release of any medical information needed to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all cost of collection, and reasonable attorney's fees. This authorization shall remain valid until written notice is given by me revoking said authorization. I further agree that a photocopy of this agreement shall be valid as the original. I understand that if I am unable to keep my scheduled appointment, I shall call to cancel at least 24 hours in advance of my scheduled appointment. I understand that a $25.00 fee may be assessed for any missed 15 to 30 minute appointment and a $50.00 fee may be assessed for any missed 60 minute appointment not previously canceled. I have received/read a copy of this office's Notice of Privacy Practice.

Date: ______________ Your Signature: ______________________________