Cook & Siu, P.C.

3450 Old Washington Rd.
Building 3450 Suite 103
Waldorf MD, 20602

Ph: (301) 472-4290

Fax: (240) 607-3609

PATIENT REGISTRATION FORM

PATIENT NAME LAST FIRST MIDDLE				DATE OF BIRTH
HOME ADDRESS APT. NO. CITY			STATE	ZIP CODE
OCCUPATION ☐ EMPLOYED ☐ RETIRED ☐ STUDENT	SOCIAL SECURITY #	MARITAL STATUS ☐S ☐M ☐D ☐W	SEX ☐M ☐F	HOME PHONE
EMPLOYER	EMPLOYER'S ADDRESS	E – MAIL ADDRESS		WORK PHONE
				CELL #
SPOUSE (OR PARENT) NAME	SPOUSE (OR PARENT) EMPLOYER			SPOUSE / PARENT WORK PHONE:
NEAREST RELATIVE/FRIEND:			HOME PHONE:	

PRIMARY INSURANCE INFORMATION

SUBCRIBER'S FIRST NAME LAST NAME		RELATIONSHIP TO PATIENT	DATE OF BIRTH
PRIMARY INSURANCE COMPANY NAME		SOCIAL SECURITY # SPOUSE:	
ADDRESS			
CITY	STATE	ZIP	
ID OR POLICY #	GROUP / CODE	EFFECTIVE DATE	

SECONDARY INSURANCE INFORMATION

SUBSCRIBER'S FIRST NAME LAST NAME		RELATIONSHIP TO PATIENT	
SECONDARY INSURANCE NAME	☐ SPOUSE OR ☐ INDIVIDUAL POLICY	ID OR POLICY #	GROUP OR CODE #
ADDRESS			
CITY	STATE	ZIP	

PATIENT AUTHORIZATION

I, _____, hereby authorize Cook & Siu, P.C. to apply for benefits on my behalf for covered services rendered. I request payment from BC/BS National Capital Area, Blue Shield of Maryland, Medicare, and / or _____ Insurance Company, be made directly to the above-named provider (or in case of Medicare Part B benefits, to myself or the party who accepts assignment).
(Name of other insurance company)

I certify that the information I have reported with regarded to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and / or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the above-named provider for any services furnished me by that physician / supplier. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits payable for related services.
(Name of Medigap Carrier)

_____ _____

DATE SIGNATURE OF SUBSCRIBER OR BENEFICIARY