

**Sinno Center for Plastic Surgery**

**PATIENT REGISTRATION FORM**

PATIENT'S NAME: \_\_\_\_\_  
FIRST MIDDLE LAST

STREET ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ SS#: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ REASON FOR VISIT: \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURANCE CARRIER: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
\_\_\_\_\_

POLICY ID# \_\_\_\_\_ SUBSCRIBER SS#: \_\_\_\_\_

GROUP#: \_\_\_\_\_ CO-PAYMENT: \_\_\_\_\_

SUBSCRIBER'S EMPLOYER: \_\_\_\_\_

**RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS**

I hereby authorize the above physician to release any information necessary to process my insurance claims and authorize Payment of medical benefits directly to Fady A. Sinno, M.D., Plastic & reconstructive surgery LLC for service provided by: Fady A. Sinno, M.D.

**I further understand that I am financially responsible for all fees which are not covered by insurance carrier.**

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