SINNO CENTER FOR PLASTIC SURGERY

Today's Date:

Prefix: Preferred Name:

Patient's Name:

First *Middle* *Last*

Address:

Street & Apt # *City* *State* *Zip*

SS#: Birthdate: Age: Sex: ❑ Female ❑Male

Marital Status: ❑ Single ❑ Married ❑ Other: Preferred Contact: ❑Home ❑ Work ❑ Cell ❑ Email

Home Phone: Work Phone: Cell Phone:

E-mail: «Person_Email» ❑ Check to be added to our mailing list _____ Initials

Emergency Contact: Relationship to Patient: Phone:

How did you hear about us? Details:

Referring Dr.: Primary Care Dr.:

Employer: Occupation:

INSURANCE INFORMATION

Primary Ins.: Insured Name:

Relationship to the insured? ❑Self ❑Child ❑Spouse ❑Other DOB: SS#:

Secondary Ins.: Insured Name:

Relationship to the insured? ❑Self ❑Child ❑Spouse ❑Other DOB: SS#:

RESPONSIBLE PARTY

Name: Ins. ID #:

Relation to Patient: Birth Date:

AGREEMENTS

PERMISSION TO DISCUSS *With whom may we discuss your account?*

Name(s):

PRIVACY PRACTICES NOTICE & WRITTEN ACKNOWLEDGEMENT FORM

I have been offered a copy of SINNO CENTER FOR PLASTIC SURGERY Notice of Privacy Practices.

Signature of Patient/Guardian: Date:

AUTHORIZATION OF PAYMENT & RELEASE OF INFORMATION

I request payment of authorized insurance benefits be paid to SINNO CENTER FOR PLASTIC SURGERY & authorize release of medical information as needed to determine payable benefits for services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

Signature of Patient/Guardian: Date:

FINANCIAL POLICY *I have received and agree to SINNO CENTER FOR PLASTIC SURGERY Financial Policy*

Signature of Patient/Guardian: Date: