Fady A. Sinno M.D., F.A.C.S.
Diplomate American Board of Plastic Surgery

WELCOME TO OUR PRACTICE

PATIENT REGISTRATION FORM

PATIENT'S NAME:_____
FIRST MIDDLE LAST

STREET ADRRESS:_____

CITY, STATE, ZIP:_____

HOME PHONE: _____WORK: _____

CELL: _____EMAIL ADDRESS: _____

DATE OF BIRTH:_____SEX:_____MARITAL STATUS:_____

EMPLOYER:_____SS#:_____

REFERRED BY: _____REASON FOR VISIT:_____

PRIVACY PRACTICES ACKNOWLEDGEMENT

I received the Notice of Privacy Practices and have been provided an opportunity to review it.

SIGNATURE _____ DATE _____

RELEASE OF INFORMATION AND ASSIGNEMENT 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 _____

Member
AMERICAN SOCIETY OF PLASTIC SURGEONS

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