Marialyn J. Sardo, MD, FACS
Certified, American Board of Plastic Surgery

Name: _____ Date: _____
First M.I. Last

Address: _____Apt:_____

City: _____State:_____ Zip: _____

Home#:_____Work#:_____May we contact you at work? Yes or No

Cell#:_____E-Mail Address: _____

S.S.N#:_____ Birthdate: _____Age:_____

Driver's License# _____State_____

Marital Status: _____Occupation:_____

Emergency Contact: _____Relationship:_____Phone:_____

Nature of visit:_____

Referred By Friend_____Dr._____Internet_____Other_____

Are you allergic to any medications: _____List:_____

Primary Physician: _____Phone:_____

Insurance Information: Please present card to photocopy, if applicable

Primary Insurance_____ Policy/ ID# _____Group_____

Policy Holders Name_____DOB_____Relationship_____

Medical Records / Authorization

I authorize the release of pertinent information to the hospital or laboratory for required care. I authorize my insurance carrier, if applicable, to release information regarding my coverage to the physician. I also authorize agents of any hospital, medical facility, or previous physician to furnish copies of any records of my treatments or medical history to Dr.Marialyn Sardo should they be needed for my care.
Full payment is to be made at the time of service. Medical insurance does not cover cosmetic procedures. I understand that I am responsible for all changes for service rendered.

Signature: _____ Date: _____

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