John A. Saugy, Jr., M.D.

Patient Registration Information

Name: ______________________________________ Date of Birth:____________ Age:_______ Sex:_______
Social Security #:______________________________ Marital Status: Single Married Widowed Divorced
Address:_____________________________________ (Apt# ______) City: ____________State:_______Zip:_________
Home Phone #:________________________Cell Phone #:____________________Work Phone #:__________________
Primary Care Physician:_________________Address:_______________________ Phone:______________________
Employer:____Occupation:_________________________________
Employer Address:____

Spouse or Parent's Name:____
Person to contact in case of emergency:__________________________________ Phone:______________________

BODY PARTS / INJURY / COMPLAINTS:____

Date of Injury:___________________
Describe How and Where Injury Occurred:____
Are you out of work due to this injury? Yes No Date Returned to Work:_______________________

ARE INJURIES RELATED TO:
An Auto Accident? YES NO A Work Related Injury? YES NO

RESPONSIBLE PARTY / POLICY HOLDER INSURANCE INFORMATION:

Responsible Party/Policy Holder:____
Relationship to Patient: self spouse parent
Date of Birth:________________________________**Social Security #:**______________________________
Address:___________________________________ **(Apt#______) City:**____________**State:**______ **Zip:**_________
Employer:____ **Work Phone #:**_______________________

INSURANCE INFORMATION:

PRIMARY Insurance Company:____
Insurance Address:_____________________________________ **City:** ____________**State:**______ **Zip:**_________
PATIENT Insurance ID #:______________________________ **Group #:**___________________________________

SECONDARY Insurance Company:____

Assignment of Benefits – Financial Agreement

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child, during the period of such care, to third party payers and/or health care practitioners.
I authorize and request my insurance company to pay directly to the doctor, or doctor's group, insurance benefits otherwise payable to me. In the event that the provider's charges are outstanding, or I fail to provide the office with the correct insurance information, I understand that I am personally responsible for payment of the provider's charges.
I have reviewed the above information and it is true and accurate.

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Signature of patient, or parent (if minor) Date