VAUGHN ORTHOPEDIC & SPINE CENTER, PLLC.
Patient Information Sheet
DEMOGRAPHICS

Patient Name: _____
First **Middle Initial** **Last**

Date of Birth: _____ **SS#** _____

Street Address & PO BOX: _____

City: _____ **State:**_____ **Zip Code:** _____

Home: (____)_____ **Cell:** (____)_____ **Work:** (____)_____

EMAIL: _____**Preferred Contact Method:** ❑Phone ❑Web

Gender: ❑ Male ❑Female **Preferred Language:** ❑English ❑Spanish Other: _____

Race: ❑Black/African-American ❑Caucasian/ White ❑Hispanic/Latino ❑Asian ❑Middle Eastern
Other: _____

Marital Status: ❑Single ❑Married ❑Separated ❑Divorced ❑Widowed

Name of Spouse: _____

Employment Status: ❑Disabled ❑Full-time ❑Part-time ❑Out of Work ❑Work with Restrictions ❑Retired ❑Student

Who may we thank for referring you? _____

Emergency Contact Name:_____**Relationship to you:** _____

Phone#:_____ **Are they listed on your HIPAA Sheet?** ❑ YES ❑NO

Preferred Pharmacy/Location: _____

I hereby authorize Vaughn Orthopedic & Spine Center, PLLC to furnish my insurance company any/all information which said insurance company (s) may request.

I understand that Vaughn Orthopedic & Spine Center, PLLC does NOT participate with ANY type of Medicaid: Americhoice, Amerigroup, BLUECARE, TNCARE, WELLCARE, etc. and therefore I will be responsible for any charges accrued during my treatment including any hospital, surgery, and office charges.

Medicare One Time Authorization. I request payment of Medicare benefits be made on my behalf to Vaughn Orthopedic & Spine Center, PLLC.

I understand that I am financially responsible to Vaughn Orthopedic & Spine Center, PLLC for all charges not covered by this assignment. . I understand that it is MY responsibility to contact my insurance to make sure that Dr. Vaughn is in my network. (THIS DOES NOT APPLY TO WORKER'S COMPENSATION PATIENTS)

I hereby assign to Vaughn Orthopedic & Spine Center, PLLC all money to which I am entitled for medical and/or surgical expenses relative to the service rendered.

I agree to pay all collection costs, court costs, and reasonable attorney fees if I fail to promptly pay this account when due and unpaid balance is turned to a collection service.

Patient Signature: _____ **Date:** _____

Please give the front desk ALL of your Medical Insurance Cards, a photo ID/Driver's License, any X-Rays, & your Co-Pay!

VAUGHN ORTHOPEDIC & SPINE CENTER, PLLC.
ACCIDENT DETAILS FOR YOUR INSURANCE/WC

Name: _____ Date of Birth: _____

Date of Injury:_____ Reason for Visit? _____

Any prior treatment for this problem? ❑ YES ❑NO If yes, when/how long ago? _____

If yes, who did you treat with prior to today? _____

_____

Is this a work-related Injury? ❑ YES ❑NO ❑UNDER LITIGATION

Is this an automobile Accident? ❑ YES ❑NO ❑UNDER LITIGATION

Do you have a Case Manager Assigned to your case? ❑ YES ❑NO If so, who? _____

Please read and sign the following:
I authorize any physician, medial practitioner, hospital, or medically related facility to give Vaughn Orthopedic & Spine Center, PLLC any information required to process my claim. This authorization includes information about drugs, alcoholism, or mental illness.

I also authorize Vaughn Orthopedic & Spine Center, PLLC to release any information obtained by insurance companies or other persons performing business or legal services in connection with my claim, or as otherwise lawfully required.

I also authorize Vaughn Orthopedic & Spine Center, PLLC to release any information requested by the Worker's Compensation Insurance, Adjuster, Case Manager, etc. in connection with my claim, or as otherwise lawfully required.

I agree that a photographic copy of this authorization shall be as valid as the original

PATIENT SIGNATURE: _____ DATE:_____