

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: \_\_\_\_\_