

**Piedmont Plastic Surgery**  
**Patient Information**

Patient Name: \_\_\_\_\_ ( Mrs. Ms. Miss Mr.)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SSN: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_

Employer: \_\_\_\_\_ Work # \_\_\_\_\_ Retired: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Referring MD: \_\_\_\_\_ City \_\_\_\_\_

Family MD: \_\_\_\_\_ City \_\_\_\_\_

**Billing Information**

Insurance Co. \_\_\_\_\_ Insured's Name \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_

*(Please make sure we have a copy of your insurance card on file)*

Workman's Compensation (if applicable) \_\_\_\_\_ Company \_\_\_\_\_

**Authorization\* Receipt of Notice of Privacy Practices\* Payment Agreement**

1. I request that payment of authorized benefits be made on my behalf to Dr. Ted Vaughn for any service furnished to me by him. I authorize any holder of medical information about me to release any information needed to determine these benefits payable. I also give Dr. Vaughn authorization to release my medical information. My medical information may be sent to Peer Review for credentialing purposes.
2. I have received a copy of Piedmont Plastic Surgery's Notice of Privacy Practices.
3. I understand that it is the policy of Piedmont Plastic Surgery to collect all co-payments and co-insurance on the day a service is rendered. As a courtesy, a claim will be filed on my behalf. If my claim is denied, for any reason, I am fully responsible to pay for my visit and/or surgery. Any outstanding balance must be paid on monthly. Any amount over 30 days delinquent will be processed for collections.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian's Signature if under 18

\_\_\_\_\_  
Date