Piedmont Plastic Surgery
Patient Information

Patient Full Names: (Miss. Mrs. Ms. Mr.)_____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Preferred Method of Contact: E-mail OR Mail

Home Phone: _____ Cell Phone: _____

Social Security #: _____ Date of Birth: _____ Age: _____ Sex: _____ Race: _____

Employer: _____ Emergency Contact: _____

Work Phone: _____ Contact Phone #: _____

Retired? _____ Relationship: _____

Family MD: _____ Pharmacy Of Choice: _____

Referring MD: _____ Pharmacy Location/Phone #: _____

Billing Information

Primary Insurance: _____ Secondary Insurance: _____

Card Holders Name: _____ Card Holders Name: _____

Date of Birth: _____ Date of Birth: _____

Social Security #: _____ Social Security #: _____

Authorization/Receipt 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. Ted Vaughn authorization to release my medical information. My medical information may be sent to peer review for credentialing purpose.
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-payment and co-insurance on the day a service is rendered.** As a courtesy, a claim will be filled 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 with in 30 days. Any account over 30 days delinquent will be processed for collections.

Patient Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

(If under 18)

Medical Information

PLEASE DESCRIBE IN YOUR OWN WORDS THE REASON YOU ARE HERE TODAY:

_____

_____

HOW LONG HAVE YOU HAD THIS PROBLEM: _____

DATE IF INJURY (IF APPLICABLE): _____

Past Medical History

PREVIOUS OPERATIONS: _____

_____

PRESENT/HISTORY OF ANY OF THE FOLLOWING:

Diabetes: _____
High Blood Pressure: _____
Heart Problems: _____
Lung Problems: _____
Other: _____

Any Bleeding Tendencies? _____

Height: _____ Weight: _____

CURRENT MEDICATIONS, DIET PILLS, VITAMINS, ETC:

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES: _____

DO YOU CURRENTLY SMOKE? _____ PACKS PER DAY? _____

FAVORITE HOBBIES: _____

HOW DID YOU LEARN ABOUT OUR PRACTICE?
Friend/Family_____ Family Doctor_____ Newspaper_____
Radio_____ Brochure_____ Yellow Pages_____

Cosmetic Surgery Patients

The Following questions, although personal, are very important. Please answer truthfully as we are the only ones that will review your answers. The type and amount of anesthesia we use is dependant on the answers to these questions.

DIET MEDICATION

Name of medication: _____

When did you start: _____

When did you stop: _____

ALCOHOL INTAKE

What form: _____

How Often and how much: _____

RECREATIONAL DRUG USE

What form: _____

Frequency: _____

Please write the word "**None**" if any of the above does not apply to you.

SIGNATURE: _____

DATE: _____