

**Amy A. Vaughan, M.D., Dermatology, PLLC**  
**6007 Rt. 60 East, Suite 130, Barboursville, WV 25504**  
**Phone: 304-733-3333/Fax: 304-733-3666**  
(Please Fill Out Completely)

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_

Last First Middle

Mailing Address \_\_\_\_\_

Street City/State Zip Code

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  Male  Female Marital Status: S  M  D  W

Social Security Number \_\_\_\_\_ Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Employer \_\_\_\_\_ How long: \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
(If not above named)

Address \_\_\_\_\_ Phone \_\_\_\_\_  
(If not listed above) Street City/State Zip Code

**Referred By** \_\_\_\_\_

Name Address City/State Zip Code

Family Physician \_\_\_\_\_

Name Address City/State Zip Code

In Case of Emergency, contact \_\_\_\_\_ Phone \_\_\_\_\_

Do we have your permission to: Leave a message regarding your appointments on your answering machine at home?  Yes  No

Leave a message regarding your appointments at your place of employment?  Yes  No

How did you hear about our practice? \_\_\_\_\_

**Please complete the following information**

Please present your insurance card(s) and your photo identification to the receptionist for scanning.

Primary Insurance Carrier \_\_\_\_\_ Group No. \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Identification No. \_\_\_\_\_

Secondary Insurance Carrier \_\_\_\_\_ Group No. \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Identification No. \_\_\_\_\_

**MEDICARE PATIENTS:** This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for consideration of a claim. Please read and sign the following statement.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

\_\_\_\_\_  
**Signature as it appears on Medicare Card** **Date**

If you have a supplemental policy and it is a **MEDIGAP** policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file. Please read and sign the following statement.

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
**Signature as it appears on MEDIGAP Card** **Date**

**PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE**

I authorize the release of any medical information necessary to process my claims and request payment of medical benefits either to myself or to the party who accepts assignment. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

\_\_\_\_\_  
**Signature of Insured or Authorized Person** **Date**

If Dr. Vaughan does not participate with my insurance company, I understand I am responsible for payment at the time of service.

\_\_\_\_\_  
**Signature of Patient (or Guardian)** **Date**