



*Vineville  
Internal  
Medicine*

Mary Bell H. Vaughn, MD

## Welcome!

Thank you for choosing to become a part of our practice. We will work very hard to ensure that you receive the best care available. Let us take this opportunity to familiarize you with our office policies:

The following is a list of what is necessary to bring to your first visit:

- Insurance cards and picture ID.
- Names and numbers of previous doctors to obtain your medical records.
- The enclosed forms completely filled out and signed.
- **All Medications you are currently taking in the bottle**

Office hours:        Monday to Thursday 7:00am to 5:00pm  
                             Friday 7:00am to 2:00pm

### Reminders:

- ***It is your responsibility to know your benefits from your insurance company. This includes wellness/physical coverage, deductible amounts, and co-payment requirements.***
- ***We use Quest laboratories for all lab work. If your insurance requires a different company to be used, it is your responsibility to tell us before labs are draw so you may be given an order sheet to go to an outside laboratory.***
- In compliance with HIPPA laws, no information will be given to anyone, including family, without prior written consent.
- We require a 24 hour cancellation notice for all appointments or a fee will be charged. Future appointments will not be available until the fee is paid.
- If your insurance company contacts you requesting information to process a claim, please contact them to prevent the bill from becoming your responsibility.
- To ensure patient care is not interrupted during the day, all calls for Dr. Vaughn will be directed to the nurses.
- We provide same day appointments for our sick patients.
- Our office is capable of ordering some medications at a wholesale price for our patients without prescription insurance. Let us know if we can help you with this.

Our goal is to provide you with the most efficient and up to date health care available. We are always open to suggestions. We look forward to seeing you!

Sincerely,  
Dr. Mary Bell Vaughn and  
Vineville Internal Medicine Staff

Your appointment is  
Scheduled on: \_\_\_\_/\_\_\_\_/\_\_\_\_



# Vineville Internal Medicine

Date \_\_\_\_\_

## PATIENT INFORMATION

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
(As appears on insurance card) Last First Initial

Sex M F Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Single Married Widowed Separated Divorced

Address \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Are you a Student Y / N Full- Time / Part-Time

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_ Occupation \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Email \_\_\_\_\_ Race \_\_\_\_\_ Religion \_\_\_\_\_

## PRIMARY INSURANCE

Primary Card Holders Name \_\_\_\_\_  
Last Name First Name Initial

Relationship to Patient \_\_\_\_\_ Birth date \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

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

Card Holder Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance Company \_\_\_\_\_

Contact # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Is Patient covered by additional insurance? Yes No

Subscriber Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Birth date \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_ Phone \_\_\_\_\_

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

Subscriber employed by \_\_\_\_\_ Business Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

## ASSIGNMENT AND RELEASE

By signing below I certify \_\_\_\_\_ has submitted true and accurate cards/information, and I understand I can be prosecuted  
(Name)  
to the full extent of the law for providing false info.

I certify that I (or my dependent) have insurance coverage with \_\_\_\_\_  
(Name of Insurance Company (ies))

I also assign directly to Dr. Mary Bell H. Vaughn all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature \_\_\_\_\_

Relation \_\_\_\_\_

Date \_\_\_\_\_

Relation	Age	State of Health	Age of Death	Cause of Death	Check (√) if, your blood relatives had any of the following:	
					Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Stroke	

Hospitalizations/Operations

Year	Hospital	Reason for Hospitalization and Outcome
Have you ever had a blood transfusion? _____		
If yes, please give approximate dates _____		
Serious Illness / Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications to Any

Health Habits

Check (√) which you use or do and describe how much you use.

	Caffeine	
	Tobacco	
	Regular Exercise	
	Sodas	
	Raw Fruit	
	Vegetables	
	Alcohol	
	Fiber	

Immunizations

Vaccine	Date Given
Tetanus/Tdap	
Pneumovax (pneumonia)	
Flu	
Gardasil (HPV)	
Varicella(chicken pox)	
Meningococcal	
Hepatitis A	
Hepatitis B	
Zostavax (shingles)	

Current Prescription Medications

Name of Drug	Dosage in Milligrams	# of Tablets	# Times Taken per Day	Prescribing Physician

Current OTC Medications (this includes vitamins and Herbal treatments)

Name of Drug	Dosage in Milligrams	# of Tablets	# Times Taken per Day	Prescribing Physician

Allergies (reaction-hives, swelling, nausea/type-allergy, side effect, lack of therapy/status-active, inactive)

Name of Drug/Food	Reaction	Type	Status

Previous Medications Taken (i.e. blood pressure-non therapeutic/cannot tolerate satins)

Name of Drug	Dosage in Milligrams	Reason No Longer Taking

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Date of last physical examination \_\_\_\_\_  
 What is your reason for visit? \_\_\_\_\_

## Conditions & Symptoms Check (✓) The Conditions or Symptoms you currently have or have had in the past year.

<p><b><u>General</u></b></p> <p>Specialist: _____</p> <p><input type="checkbox"/> Appendicitis</p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Chicken Pox</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Hernia</p> <p><input type="checkbox"/> Loss of sleep</p> <p><input type="checkbox"/> Loss of weight</p> <p><input type="checkbox"/> Organ Transplant</p> <hr/> <p><input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> Sweats</p> <p><input type="checkbox"/> Measles</p> <p><input type="checkbox"/> Mononucleosis</p> <p><input type="checkbox"/> Mumps</p> <p><input type="checkbox"/> Polio</p>	<p><b><u>Gastrointestinal</u></b></p> <p>Specialist: _____</p> <p><input type="checkbox"/> Appetite poor</p> <p><input type="checkbox"/> Bloating</p> <p><input type="checkbox"/> Bowel Changes</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Excessive hunger</p> <p><input type="checkbox"/> Excessive thirst</p> <p><input type="checkbox"/> Gas</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> Liver Disease</p> <p><input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Rectal Bleeding</p> <p><input type="checkbox"/> Stomach pain</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Vomiting blood</p>	<p><b><u>Ophthalmology</u></b></p> <p>Specialist: _____</p> <p><input type="checkbox"/> Cataracts</p> <p><input type="checkbox"/> Crossed eyes</p> <p><input type="checkbox"/> Blurred vision</p> <p><input type="checkbox"/> Double vision</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Vision – Flashes</p> <p><input type="checkbox"/> Vision – Halos</p>	<p><b><u>Skin</u></b></p> <p>Specialist: _____</p> <p><input type="checkbox"/> Acne</p> <p><input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Change in moles</p> <p><input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Redness</p> <p><input type="checkbox"/> Scars</p> <p><input type="checkbox"/> Sore that won't heal</p>
<p><b><u>Muscle/Joint/Bone</u></b></p> <p>Specialist: _____</p> <p>Pain, weakness or numbness in:</p> <p><input type="checkbox"/> Arms                      Hips</p> <p><input type="checkbox"/> Back                        Legs</p> <p><input type="checkbox"/> Feet                         Neck</p> <p><input type="checkbox"/> Hands                      Shoulders</p> <p><input type="checkbox"/> Arthritis</p>	<p><b><u>Psychiatric</u></b></p> <p>Specialist: _____</p> <p><input type="checkbox"/> Alcoholism</p> <p><input type="checkbox"/> Anorexia</p> <p><input type="checkbox"/> Bulimia</p> <p><input type="checkbox"/> Chemical Dependency</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Nervousness</p> <p><input type="checkbox"/> Psychiatric Care</p> <p><input type="checkbox"/> Suicide Attempt</p>	<p><b><u>Cardiovascular</u></b></p> <p>Specialist: _____</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Heart Disease</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> High Cholesterol</p> <p><input type="checkbox"/> Irregular heart beat</p> <p><input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> Poor circulation</p> <p><input type="checkbox"/> Rapid heart beat</p> <p><input type="checkbox"/> Swelling of ankles</p> <p><input type="checkbox"/> Varicose veins</p>	<p><b><u>Genito-Urinary</u></b></p> <p>Specialist: _____</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Lack of bladder control</p> <p><input type="checkbox"/> Painful urination</p> <p><input type="checkbox"/> Gonorrhea</p> <p><input type="checkbox"/> Herpes</p>
<p><b><u>Infectious Diseases</u></b></p> <p>Specialist: _____</p> <p><input type="checkbox"/> AIDS</p> <p><input type="checkbox"/> HIV Positive</p> <p><input type="checkbox"/> Typhoid Fever</p> <p><input type="checkbox"/> Venereal Disease</p>	<p><b><u>Hematology/Oncology</u></b></p> <p>Specialist: _____</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Bleeding disorders</p> <p><input type="checkbox"/> Cancer</p>	<p><b><u>Neurological</u></b></p> <p>Specialist: _____</p> <p><input type="checkbox"/> Forgetfulness</p> <p><input type="checkbox"/> Headache</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Migraine Headaches</p> <p><input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> Stroke</p>	<p><b><u>MEN only</u></b></p> <p><input type="checkbox"/> Breast lump</p> <p><input type="checkbox"/> Erection difficulties</p> <p><input type="checkbox"/> Lump in testicles</p> <p><input type="checkbox"/> Penis discharge</p> <p><input type="checkbox"/> Prostate Problem</p> <p><input type="checkbox"/> Sore on penis</p> <p><input type="checkbox"/> Other</p>
<p><b><u>Pulmonary</u></b></p> <p>Specialist: _____</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Asthma</p>	<p><b><u>Rheumatology</u></b></p> <p>Specialist: _____</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> Scarlet Fever</p>	<p><b><u>Ear, Nose, &amp; Throat</u></b></p> <p>Specialist: _____</p> <p><input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> Bleeding gums</p> <p><input type="checkbox"/> Difficulty swallowing</p> <p><input type="checkbox"/> Earache</p> <p><input type="checkbox"/> Ear discharge</p> <p><input type="checkbox"/> Hay fever</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Loss of hearing</p> <p><input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/> Persistent cough</p> <p><input type="checkbox"/> Ringing in ears</p> <p><input type="checkbox"/> Sinus problems</p> <p><input type="checkbox"/> Tonsillitis</p>	<p><b><u>WOMEN only</u></b></p> <p><input type="checkbox"/> Abnormal Pap Smear</p> <p><input type="checkbox"/> Bleeding between periods</p> <p><input type="checkbox"/> Breast lump</p> <p><input type="checkbox"/> Extreme menstrual pain</p> <p><input type="checkbox"/> Hot flashes</p> <p><input type="checkbox"/> Miscarriage</p> <p><input type="checkbox"/> Nipple discharge</p> <p><input type="checkbox"/> Painful intercourse</p> <p><input type="checkbox"/> Vaginal discharge</p> <p><input type="checkbox"/> Vaginal Infections</p> <p><input type="checkbox"/> Other</p>
<p><b><u>Endocrinology</u></b></p> <p>Specialist: _____</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Goiter</p> <p><input type="checkbox"/> Thyroid Problems</p>	<p><b><u>Nephrology</u></b></p> <p>Specialist: _____</p> <p><input type="checkbox"/> Kidney Disease</p> <p><input type="checkbox"/> Dialysis Treatment</p>	<p>Date of last: _____</p> <p>Menstrual period _____</p> <p>Pap smear _____</p> <p>Mammogram _____</p> <p>Chest X-Ray _____</p> <p>Echo _____</p> <p>Colonoscopy _____</p>	