Welcome

WELCOME TO OUR OFFICE! Please take a few minutes to complete the following questions as accurately as possible. In addition, we will need to make photocopies of your insurance cards. Should you require assistance, we will be glad to help you.

PATIENT INFORMATION (confidential)

Last name, First Name, M.I.

Mailing Address | City | Zip Code

Street Address (If different than mailing address) | City | Zip Code

Phone Number | Date of Birth | Social Security Number | General Physician

Employer | City | Phone Number

□ Female □ Male Who Recommended you to our office? □ Dr. ___________ □ Friend □ Phone Book

□ Single □ Minor □ Divorced □ Widowed □ Married (Spouse's Name) □ Other ____________________

RESPONSIBLE PARTY (If Patient is a Minor)

Last Name, First Name, M.I.

Mailing Address (If different) | Phone Number

Employer | City | Phone Number

Relationship to Patient: □ Self □ Parent □ Legal Guardian □ Spouse □ Other ______________________________

EMERGENCY NOTIFICATION

In the event of an emergency, please list the person we should contact (**other than your spouse**)

Name | Relationship to Patient | Phone Number

TREATMENT AUTHORIZATION

ALAN D. SAMPSON, M.D. agrees to provide medical care and services to the best of his skill and knowledge. By your signature below, you agree to cooperate with ALAN D. SAMPSON, M.D., by adhering to the treatment regimen and course of action as set forth, by obtaining such medications as are prescribed, and by following the instructions of ALAN D. SAMPSON, M.D. to the best of your ability.

Patient Signature ____________________________________ **Date** ___________________

If the patient is a minor or is incapable of signing his/her name, the parents or representative should sign below.

□ Parent □ Legal Guardian □ Representative

____ **Date** ____________________

PLEASE CONTINUE ON BACK OF THIS FORM

INSURANCE INFORMATION (Please present all health insurance cards to receptionist)

INSURANCE COMPANY	NAME OF INSURED	DATE OF BIRTH	SOCIAL SECURITY #	EMPLOYERS'S NAME

CO-PAYMENTS AND DEDUCTIBLES

Co-payments are part of the financial arrangement that you have made with your insurance carrier, If you have a co-payment required for office visits, we are obligated to collect this amount before services are rendered. This amount will be collected each time you present for an office visit. Please list below the co-payment amounts that you have for the insurance companies that you have listed above.

In addition, many private insurance companies require that the patient meet an annual deductible before payment for services are made to Dr. Sampson. Please list below your annual deductible amount and any outstanding deductible amount you may have for the insurance companies that you have listed above.

INSURANCE COMPANY	Co-Payment for Office Visit	Annual Deductible	Remaining Deductible

FINANCIAL RESPONSIBILITY

Payment for service is due at the time the service is provided in out office. As a courtesy to you, we will bill most primary and secondary insurance carries for you. However, this does not relieve you from your responsibility to ensure that full payment is made for the services that you receive. Once payment or notice of nonpayment is received from your insurance carrier, we will bill you for the balance on your account.

- MEDICARE PATIENTS - We are a Medicare provider and will bill Medicare for you. Please provide the receptionist with your Medicare card and any secondary medical insurance cards that you may have. Once we have received payment from your insurance carrier(s) we will bill you for the balance. Please note that the current annual Medicare deductible is $155.

- MEDI-CAL PATIENTS – Please provide the receptionist with your current Medi-Cal card. If you are not eligible to receive Medi-Cal benefits for the current month, we will require that you pay in full for the services that you receive in our office. If you have a Share of Cost that has not been met for the current month, we are required to collect payment for the services that you will receive.

- PRIVATE INSURANCE – Please note that we must have current, accurate insurance information to submit your claim to your insurance carrier. If we are unable to verify your insurance information, we will request payment at the time of service and will provide you with the information that you will need to submit the claim to your insurance carrier. If your insurance information changes, please notify our office when presenting for subsequent visits.

By your signature below, you agree to pay to Alan D. Sampson, M.D. all fees and charges for services that you receive from our office. You understand that our office will bill your insurance company as a courtesy to you, but that this does not relieve you of your responsibility to ensure that full payment is made for these services. By signing below, you authorize the release of any medical information necessary to process your insurance claim(s). You also authorize and request payment of medical benefits relating to the services that you receive effect until you revoke such authorization in writing.

Patient Signature________________________________ **Date**______________________

If the patient in a minor or is incapable of signing his/her name, the parent, legal guardian, or representative should sign below.

□ Parent □ Legal Guardian □ Representative

____ **Date**______________________

PATIENT MEDICAL HISTORY

Patient Name: ______________________________ Date of Birth: ___/___/___

What is the reason for your visit to our office today? ______________________________

____

When was your last eye examination? ____________ by Dr. ______________________

When was your last physical examination? ____________by Dr. ______________________

Are you currently under medical treatment? ❒ No ❒ Yes, for ______________________

Do you smoke? ❒ No ❒ Yes, #____ of packs per day for ____ years.

Number of alcoholic beverages you drink per week: ❒ None ❒ 1-5 ❒ 6-10 ❒ 11-15 ❒ 16-20 ❒ 20+

Please list any recreational drugs that you use: ______________________________

Have you ever had any allergic reaction to the following:

- ❒ Sulfa Drugs
- ❒ Penicillin or other Antibiotics
- ❒ Local Anesthetics (e.g. Novocaine)
- ❒ Other Drugs ______________________

What is your ethnic background?

- ❒ Caucasian
- ❒ Eskimo
- ❒ East Indian
- ❒ African American
- ❒ Native American
- ❒ West Indian
- ❒ Hispanic
- ❒ African
- ❒ Mid-East
- ❒ Asian ______________________
- ❒ Pacific Islander ______________
- ❒ Other______________________

Have you ever had any of the following:

- ❒ Diabetes
- ❒ Hypertension
- ❒ Heart Disease
- ❒ Thyroid Disease
- ❒ A.I.D.S.
- ❒ H.I.V.
- ❒ Multiple Sclerosis
- ❒ Rheumatoid Arthritis
- ❒ High Cholesterol
- ❒ Lyme's Disease
- ❒ Stroke
- ❒ Migraine Headaches
- ❒ Cataracts
- ❒ Glaucoma
- ❒ Retinal Disorders
- ❒ Eye Surgery
- ❒ Blindness
- ❒ Other ______________

Please list all major surgery that you have had in the past:

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Please check all of the following eye conditions that you currently are experiencing:

- ❒ Blurred Vision
- ❒ Blind Spots in Vision
- ❒ Poor Side Vision
- ❒ Poor Night Vision
- ❒ Poor Color Vision
- ❒ Poor Depth Perception
- ❒ Sensitivity to Light
- ❒ Halos around Lights
- ❒ Problems w/Glare
- ❒ Red Eyes
- ❒ Puffy Eyes
- ❒ Eye Discomfort
- ❒ Dry Eyes
- ❒ "Lazy" Eye
- ❒ Light Flashes
- ❒ Jagged Lines of Vision
- ❒ Eye Infection
- ❒ Crusting or Red Eyelids
- ❒ Retraction of Eyelid
- ❒ Abnormal Pupil
- ❒ Floaters
- ❒ Abnormal Blinking
- ❒ Eyelid Spasm
- ❒ Tearing of Eye
- ❒ Eye Irritation
- ❒ Pressure behind Eye
- ❒ Other ______________

Is there a family history of: ❒ Glaucoma ❒ Macular Degeneration ❒ Cataracts ❒ Diabetes ❒ Retinal ❒ Blindness

Please list all medications that you currently use:____________ ____________ ____________

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