

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.

Last name, First Name, M.I.

[illegible]

Zip Code

Prices are made to the sample. Please see below your annual schedule amount and any outstanding receivable

Zip Code

[illegible]

General Physician

[illegible]

Phone Number

Full payment is made for the services only on receipt of invoice and/or notice of abandonment is received from

- ☐ Female ☐ Male Who Recommended you to our office? ☐ Dr. _____ ☐ Friend ☐ Phone Book
☐ Single ☐ Minor ☐ Divorced ☐ Widowed ☐ Married (Spouse's Name) ☐ Other _____

Last Name, First Name, M.I.

[illegible]

Phone Number

that you receive in our office? You have a share of Cost that has not been met for the church front, we are

Phone Number

[illegible]

Relationship to Patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Spouse ☐ Other _____

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

Phone Number

By continuing to use the site, you agree to the use of cookies. For more information, please see our Cookie Policy.

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.

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 _____

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:

- | | |
|--|---|
| <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Local Anesthetics (e.g. Novocaine) |
| <input type="checkbox"/> Penicillin or other Antibiotics | <input type="checkbox"/> Other Drugs _____ |

What is your ethnic background?

- | | | | |
|--------------------------------------|---|-----------------------------------|---|
| <input type="checkbox"/> Caucasian | <input type="checkbox"/> African American | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Asian _____ |
| <input type="checkbox"/> Eskimo | <input type="checkbox"/> Native American | <input type="checkbox"/> African | <input type="checkbox"/> Pacific Islander _____ |
| <input type="checkbox"/> East Indian | <input type="checkbox"/> West Indian | <input type="checkbox"/> Mid-East | <input type="checkbox"/> Other _____ |

Have you ever had any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Retinal Disorders |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Lyme's Disease | <input type="checkbox"/> Eye Surgery |
| <input type="checkbox"/> A.I.D.S. | <input type="checkbox"/> Stroke | <input type="checkbox"/> Blindness |
| <input type="checkbox"/> H.I.V. | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Other _____ |

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

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

Is there a family history of: ☐ Glaucoma ☐ Macular Degeneration ☐ Cataracts
☐ Diabetes ☐ Retinal Disease/Surgery ☐ Blindness

Please list all medications that you currently use: _____

