

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.

Date

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agree to cooperate w medications as are p																											7.				ng su
Patient Signature			o.																				Da	te							
If the patient is a min		ncapab	le of	signii	ng h	is/h	er n	am	e, th	ne p	arer	its o	r re	pre	sen	tati	ve	sho	ulc	lsi	gn l	pelo	ow.	107	101	1111	1 15	ni i	n yi	ляq	frinc - Day
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## \*\*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
Simple directions on creening and	onor our stordings or	-Ammun		
if need to make photocopies o	ac, in addition, we w	resort six	I H WA WAY	图 Alman 人用 VIII

## CO-PAYMENTS AND DEDUCTIBLES ON glod or beig od

your insurance cards. Should you require assistance, we will

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.

DIGUID AND COMPANIE	G D . C OCC 17"	1 1 1 1 1 1 1 1 1	D :: D 1 .:11
INSURANCE COMPANY	Co-Payment for Office Visit	Annual Deductible	Remaining Deductible
ieneral Physician	scial Security Number (	te of Birth S	hone Number Da

## 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 Sign	nature ability our ability	v D. SAMPSON, M.D. to the l	Date Date	is are prescribed, and by following	a sherisətəsi
If the patient	in a minor or is incap	pable of signing his/her name	e, the parent, legal guardian,	or representative should s	ign below.
- Parent	□ Legal Guardian	Representative	Date	c Legal Guardian	Parent

Patient Name:				Date of Birth:	1 1	
Patient Name:				Date of Birth:	9	
What is the reason for your v	visit to our office to	oday?				
When was your last eye exar	nination?	k	oy Dr	*	72	
When was your last physical	examination?	b	y Dr			
Are you currently under med	ical treatment?	J No □	Yes, for		300.436.2567.3567.	
Do you smoke? ☐ No	☐ Yes, # of	packs per da	ay for y	ears.		
Number of alcoholic beverag	es you drink per v	veek:		□ 1-5 □ 11-15	□ 6-10 □ 16-20	□ 20+
Please list any recreational d	lrugs that you use	:				
Have you ever had any allerg	ic reaction to the	following:				
☐ Sulfa Drugs ☐ Penicillin or other	Antibiotics			ics (e.g. Novocaine		
What is your ethnic backgro	und?					
☐ Caucasian ☐ Afri	can American	J Hispanic	☐ Asian _	slander		
☐ East Indian ☐ We		J Mid-East		Siander		
Have you ever had any of the						
☐ Diabetes ☐ Hypertension		le Sclerosis natoid Arthr		☐ Cataracts ☐ Glaucoma		
Heart Disease		Cholesterol	itis	☐ Retinal Di		
☐ Thyroid Disease		s Disease		☐ Eye Surge		
□ A.I.D.S.	☐ Stroke			☐ Blindness		
□ H.I.V.	☐ Migrai	ne Headach	es	☐ Other	-	
Please check all of the follow	ring eye conditions	s that you c	urrently are e	experiencing:		_
☐ Blurred Vision	☐ Red E			☐ Retraction		
Blind Spots in Vision	☐ Puffy I			☐ Abnormal	Pupil	
☐ Poor Side Vision		scomfort		☐ Floaters	Dlinking	
☐ Poor Night Vision ☐ Poor Color Vision	☐ Dry Ey ☐ "Lazy"			☐ Abnormal I ☐ Eyelid Spa		
☐ Poor Depth Perception	☐ Light F			☐ Tearing of		
☐ Sensitivity to Light		d Lines of V	ision	☐ Eye Irritation		
☐ Halos around Lights	☐ Eye In:			☐ Pressure b		
☐ Problems w/Glare	☐ Crusti	ng or Red E	yelids	□ Other	-	
Is there a family history of:	☐ Glaucoma	☐ Macular I	Degeneration	□ Cataracts		
	□Diabetes	☐ Retinal D	isease/Surge	ery	s	
Please list all medications th	at you currently us	se:				
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