

THOMAS G. SAMPSON, M.D., A PROFESSIONAL CORPORATION

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(415) 345-9400 (tel) • (415) 345-8049 (fax)

Confidential Intake Form

(To safeguard your information, please do not e-mail this form to us)

Contact Information

LAST NAME	FIRST NAME (ANY INITIALS; NAME YOU GO BY)	MR. MS. MRS. DR. OTHER/NONE	
ADDRESS	HOME TELEPHONE	CELL	
	WORK TELEPHONE	FAX	
E-MAIL	ALTERNATE E-MAIL		
OCCUPATION	DATE OF BIRTH	AGE	SOCIAL SECURITY NUMBER
EMPLOYER	EMPLOYER ADDRESS		
EMPLOYER TELEPHONE			
FULL NAME OF SPOUSE	SPOUSE'S EMPLOYER		
SPOUSE'S CONTACT TELEPHONE NUMBER	SPOUSE'S WORK NUMBER		
OTHER EMERGENCY CONTACT PERSON	OTHER EMERGENCY CONTACT PERSON'S NUMBER		

Referral Information

REFERRED BY	PRIMARY CARE DOCTOR
REFERRING DOCTOR'S ADDRESS	

Reason for Visit (and Related Information)

WHICH PART OF THE BODY DOES THIS CONCERN?		RIGHT SIDE	LEFT SIDE
IS THIS AN ILLNESS?	IS THIS AN INJURY?	HOW LONG HAVE YOU HAD THIS ISSUE? (DATE OF ONSET OR INJURY)	
IF THIS IS AN INJURY, IT HAPPENED . . .			
<input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> DURING A SPORTS ACTIVITY <input type="checkbox"/> AS THE RESULT OF AN AUTOMOBILE ACCIDENT			
NAME(S) AND CONTACT INFORMATION OF ANY OTHER DOCTOR(S) YOU HAVE SEEN FOR THIS			
ARE ANY RELATED RECORDS AVAILABLE?		X-RAYS	MRI CT EMG
PURPOSE OF APPOINTMENT			
<input type="checkbox"/> CONSULTATION ONLY <input type="checkbox"/> CONSULTATION AND TREATMENT <input type="checkbox"/> SECOND OPINION			

Insurance Information

—PLEASE PROVIDE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST—

NAME OF PRIMARY INSURANCE PROVIDER	ID NUMBER		
NAME OF SUBSCRIBER	GROUP NUMBER	EFFECTIVE DATE	
YOUR RELATIONSHIP TO SUBSCRIBER	CONTACT TELEPHONE NUMBER FOR PRIMARY INSURANCE PROVIDER		
SUBSCRIBER'S SOCIAL SECURITY NUMBER	SUBSCRIBER'S DATE OF BIRTH		
NAME OF SECONDARY INSURANCE PROVIDER	ID NUMBER		
NAME OF SUBSCRIBER	GROUP NUMBER	EFFECTIVE DATE	
YOUR RELATIONSHIP TO SUBSCRIBER	CONTACT TELEPHONE NUMBER FOR SECONDARY INSURANCE PROVIDER		
SUBSCRIBER'S SOCIAL SECURITY NUMBER	SUBSCRIBER'S DATE OF BIRTH		

TO OUR PATIENTS: Please note that Dr. Sampson is not a provider of any insurance and that payment is due at the time of service, with the exception of Workers' Compensation. Accordingly, we will gladly provide you with a "superbill" you can forward to your insurance company for reimbursement. If you require surgery, we will bill your insurance carrier on your behalf. Your signature below indicates your agreement to this policy and authorizes the release of any medical or other information necessary to process your claim or claims. You also authorize payment of medical benefits, from your insurance, to Dr. Sampson for services he provides.

Date: _____

Patient Acknowledgment: _____