

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

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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
CITY/STATE/ZIP			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: _____