THOMAS G. SAMPSON, M.D., A PROFESSIONAL CORPORATION
2299 Post Street, Suite 107 • San Francisco, CA 94115
(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
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 . . .	AT WORK AT HOME	DURING A SPORTS ACTIVITY	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	CONSULTATION ONLY	CONSULTATION AND TREATMENT	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: _____

Patient Pain Drawing

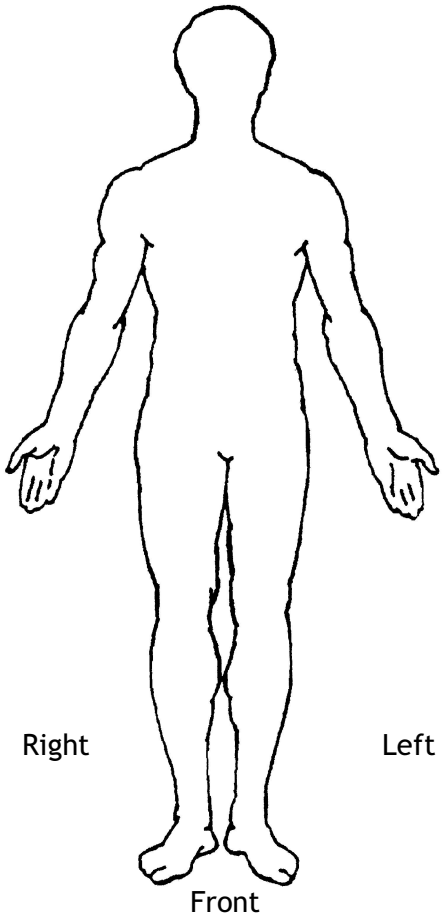
_____ _____

Name Date

Where is your pain now?

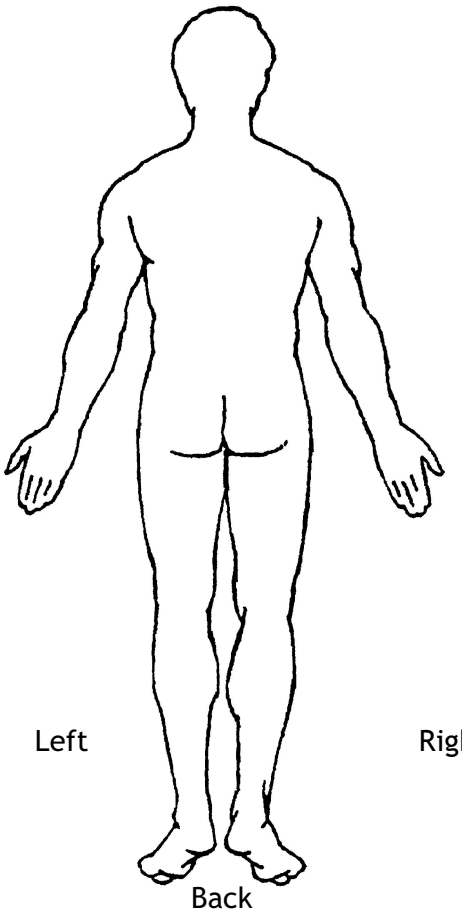
- Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.
- Mark the areas of radiation.
- Include all affected areas.
- To complete the picture, please draw in your face.

Aching	Numbness	Pins and needles	Burning	Stabbing
▲ ▲ ▲	= = =	○ ○ ○	× × ×	/ / /



Right Left

Front



Left Right

Back

How bad is your pain now?

- Please mark with an X on the body form where the pain is worst now.
- Please mark on the line how bad your pain is now:

No pain _____ Worst possible pain