Los Angeles Special Care Medical Associates
Hollywood

LASCMA -- HOLLYWOOD OFFICE OF MICHAEL SAMPSON, MD
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A/ CONFIDENTIAL PATIENT INFORMATION

NAME (LAST, FIRST:) _____ , _____ SOCIAL SECURITY # : __ __ __ __ __ __ __ __ __

STREET ADDRESS: _____ APT/HOUSE#: _____ CITY: _____ STATE: ☐☐ ZIP: ☐☐☐☐☐

HOME PHONE*: _____ PRIMARY E-MAIL: _____ BIRTH-DATE: __ __/__ __/__ __ __ __

EMPLOYER: _____ WORK PHONE*: _____ WORK ADDRESS: _____

EMERGENCY CONTACT NAME -- RELATION: _____ -- _____ E.C. PHONE*: _____

IF YOU WERE REFERRED TO US, MAY WE ASK HOW OR BY WHOM? _____

B/ PRIMARY INSURANCE *(REMEMBER TO BRING YOUR INSURANCE CARDS WITH YOU TO EACH & EVERY VISIT.)*

PRIMARY INSURANCE CARRIER: _____ PRIMARY INS TYPE: PPO HMO PRIV IND MCARE

MEMBER SUBSCRIBER ID#: _____ DATE EFFECTIVE : __ __/__ __/__ __ __ __

PERSON RESPONSIBLE FOR THIS ACCNT: ☐ SELF (GO TO NEXT SECTION) NAME (LAST, FIRST:) _____ , _____

RELATIONSHIP TO PERSON: _____ SOC SEC #: ☐☐☐☐☐☐☐☐☐ BIRTH-DATE: __ __/__ __/__ __ __ __

HOME ADDRESS: _____ CITY: _____ STATE: ☐☐ ZI P: ☐☐☐☐☐

HOME PHONE*: _____ PRIMARY E-MAIL: _____

C/ SECONDARY INSURANCE

☐ IF NOT APPLICABLE, CHECK THIS BOX THEN MOVE CURSER TO NEXT SECTION

SECONDARY INSURANCE CARRIER: _____ SECONDARY INS TYPE: PPO HMO PRIV IND MCARE

MEMBER SUBSCRIBER ID#: _____ DATE EFFECTIVE : __ __/__ __/__ __ __ __

PERSON RESPONSIBLE FOR THIS ACCNT: ☐ SELF (GO TO NEXT SECTION) NAME(LAST, FIRST:) _____ , _____

RELATIONSHIP TO PERSON: _____ SOC SEC#: ☐☐☐☐☐☐☐☐☐ BIRTH-DATE: __ __/__ __/__ __ __ __

HOME ADDRESS: _____ CITY: _____ STATE: ☐☐ ZI P: ☐☐☐☐☐

HOME PHONE*: _____ PRIMARY E-MAIL: _____

D/ ASSIGNMENT OF INSURANCE BENEFITS AND CLIENT AGREEMENT

--> I HEREBY AUTHORIZE PAYMENT DIRECTLY TO LASCMA / DR. SAMPSON (OR SPECIFIED AFFILIATE) OF ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR THE SERVICES RENDERED.

--> I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES,WHETHER OR NOT PAID BY INSURANCE & FOR ALL SERVICES RENDERED ON BEHALF OF MY DEPENDENTS.

--> I AUTHORIZE DR. SAMPSON &/OR ANY PROVIDER OR SUPPLIER OF SERVICE IN THIS OFFICE TO RELEASE INFORMATION REQUIRED TO SECURE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS.

☐ CHECK HERE IF YOU AGREE ☐ CHECK HERE IF YOU DISAGREE

SIGNATURE: _____

DATE: _____