W. Sam Shields, O.D.
& associates

2812 Cochran Street, Simi Valley, Ca 93065
Phone: 805.527.6164 Fax: 805.527.4391
www.drwsamshields4eyes.com

Welcome to the practice of W. Sam Shields, O.D. and associates.

Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you have placed in us. Please take a moment to complete the following information. We ask that you kindly bring this form to your scheduled appointment or fax it back to us prior to your exam. If you have any questions, please do not hesitate to call.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name ______ MI ______ Last Name ______ Preferred Name ______

Street Address ______ City ______ State ______ Zip ______

Social Security Number ______ Date of Birth ______ Home Phone ______ Work Phone ______

Email ______ Spouse or Parent(s) Name ______ Person Responsible for Account ______

Emergency Contact ______ Emergency Phone ______ Patient Occupation ______

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient (Please Name)______

☐ Insurance ☐ Drive by ☐ Other ☐ Doctor (Please Name)______

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company ______ City ______ State ______ Zip ______

☐ M ☐ F Insured's First Name ______ MI ______ Insured's Last Name ______

Insured's Identification Number ______ Group Number ______ Insured's Date of Birth ______

Patient Relationship to Insured: Patient Status: ☐ Single ☐ Married ☐ Other ______

☐ Self ☐ Spouse ☐ Child ☐ Other______ ☐ Full Time Student ☐ Part time Student ☐ Employed

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned patient or legally authorized representative of the patient acknowledges that he or she personally reviewed the Notice of Privacy Policies for W. Sam Shields and associates on the date indicated below. The Notice of Privacy Practices are posted on our website and are available in our office.

Signature ______ Date ______

PLEASE READ AND ACKNOWLEDGE:

In order to control the cost of billing, we ask that the patient's portion be paid at the time the services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. These will be a service charge in all returned checks.

Payment from my insurance is to be paid directly to Dr. W. Sam Shields. I understand that if I have listed a primary insurance company above, it will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature ______ Date ______

"It's not what you look at that matters, it's what you see."