Mark C. Campbell, D.C.
Placentia, CA 92870
(714) 572-8777

Date ___/___/_____
Case Id# _________

PATIENT INFORMATION

Last Name ________________________ First Name ________________________ Middle Initial ____
Address ____
City _____________________________ State _______ Zip _________________
Phone ___________________________ Work Phone _______________________ E-mail _______________________
Cell Phone ________________________ Fax # ________________________
SS# ______________________________ Driver's License # ________________
Birth Date _________________________ Age ______
Sex: ❒ M ❒ F Student? ❒ No ❒ Part time ❒ Full time
❒ Single ❒ Married ❒ Divorced ❒ Widow Spouse ____________________ How many children?_______________
❒ Mr. ❒ Ms. ❒ Mrs. ❒ Miss ❒ Dr.
❒ Unemployed ❒ Full ❒ Part ❒ Retired ❒ Disabled ❒ Self-employed

EMPLOYER INFORMATION

Occupation _______________________ Employer ___________________________
Address __________________________ City _______________________________ State _______ Zip ___________

EMERGENCY CONTACT

Name _____________________________ Relationship _____________________ Phone ________________________

CASE HISTORY

How were you referred to our office? ______________________________________
Family Medical Doctor ____
Purpose of this appointment ____
Date symptoms appeared or accident happened ______________________________
Is the condition we are treating related to current or previous employment? ❒ Yes ❒ No
Is the condition we are treating related to an auto accident? ❒ Yes ❒ No
Is the condition we are treating related to another type of accident? ❒ Yes ❒ No
Have you ever had the same or a similar condition? ❒ Yes ❒ No
If yes, when and describe: ____
Have you ever been disabled? ❒ Yes ❒ No
Days lost from work __________________
Date of last physical examination ______________________

WOMEN ONLY:
Are you pregnant at this time? ❒ Yes ❒ No

What surgeries have you had? (Include dates) ____
Serious illnesses: ❒ Cancer ❒ Diabetes ❒ High Blood Pressure ❒ Heart disease ❒ HIV/AIDS ❒ Osteoporosis
❒ Pacemaker ❒ Rhematoid Arthritis ❒ Tuberculosis ❒ Other____
Have you been treated for any health condition by a physician in the last year? ❒ Yes ❒ No
If yes, describe: ____
What medications or drugs are you taking? ____
Height: Feet _______ Inches _______ Weight: _______________
Hobbies ____

CONSENT TO TREATMENT OF A MINOR: I being the parent or guardian of the above patient do hereby consent, authorize and request Mark C. Campbell, D.C., and whomever he may designate as his assistant, to administer such treatment deemed advisable, necessary or requested for this minor.

Guardian's Signature Authorizing Care ____ Date ____________

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 18%.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature ____ Date ____________