Name: _____ Date of Visit: _____

PLEASE PRINT If you need additional space write on another sheet & attach

CHIEF COMPLAINT: (What is the main problem for which you have an appointment this visit?)

_____

_____

HISTORY OF PRESENT ILLNESS: (When, where and how did the problem begin?) Be detailed.

_____

_____

_____

_____

Describe all prior spinal problems that you have had, even if resolved:

_____

_____

_____

MEDICATIONS: (Please list & include dosage. Include non-prescription medications and supplements)

Medication Name	Dosage	Medication Name	Dosage

MEDICATION ALLERGIES:

_____

_____

TESTS: (Tell us about New MRI, CT scans, or other tests you have had for your spinal problem and list the date performed.)

_____

_____

_____

PAST MEDICAL PROBLEMS & SURGERIES: (List your past experiences with other illnesses, operations, injuries and treatments)

_____

_____

_____

_____

Implants/surgical or other metal inside the body: Type_____ Location_____

If problems with anesthesia, please describe_____

FAMILY HISTORY :(Indicate family history of medical events of your parents/siblings including diseases which may be hereditary)

_____

_____

_____

SOCIAL HISTORY:

Your current work status_____ Occupation: _____

Alcohol Intake ❑Yes ❑No If yes, how much_____/Day _____Week

Tobacco use ❑Yes ❑No If yes, how much_____/Day _____Week

Caffeine: ❑Yes ❑No If yes, how much per day_____ Recreational drugs: ❑Yes ❑No

Do You See your Primary Care Physician for regular checkups ❑Yes ❑No

Exercise Routine: _____

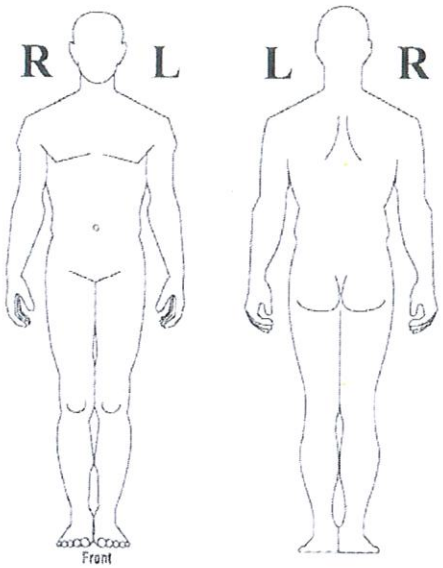
David Campbell MDPA

Initial Visit

NAME: _____ DATE: _____

Mark your pain on the body outline with the represented letter and mark how bad your pain is on a scale of 1-10.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
A	B	N	P	S	X



Mark Your Pain Estimate

Name: _____ Date: _____

Please bubble in the sheet below:

Review of Systems: (Do you have?)

General

Unexplained weight change	O Yes	O No
Fatigue	O Yes	O No
Loss of appetite	O Yes	O No
Fever or Chills	O Yes	O No

Skin

Rash	O Yes	O No
Itching	O Yes	O No
Lesions	O Yes	O No

HEENT

Headache	O Yes	O No
Vision change	O Yes	O No
Hearing change	O Yes	O No

Hematology

Easy bruising/bleeding	O Yes	O No

Lungs

Shortness of breath	O Yes	O No
Cough	O Yes	O No
Wheezing	O Yes	O No

Cardiac

Chest pain	O Yes	O No
Palpitations	O Yes	O No
Murmur	O Yes	O No

GI

Heartburn	O Yes	O No
Reflux	O Yes	O No
Nausea	O Yes	O No
Vomiting	O Yes	O No
Bowel Problems	O Yes	O No

Musculoskeletal

Muscle pain	O Yes	O No
Joint pain	O Yes	O No
Swelling	O Yes	O No
Spasm	O Yes	O No
Stiffness	O Yes	O No
Loss of motion	O Yes	O No

GU

Urinary Problems	O Yes	O No
Sexual Problems	O Yes	O No

Neurologic

Weakness	O Yes	O No
Numbness	O Yes	O No

Endocrine

Hair/voice change	O Yes	O No

Psychiatric

Difficulty sleeping	O Yes	O No
Psychiatric Illness	O Yes	O No
Mood Swings	O Yes	O No

David Campbell MDPA

Last Name_____First Name _____MI____

Address_____ City_____St ____Zip_____

Main # _____ Secondary # _____

*Email Address_____Date of Birth _____ Sex_____

*Race_____*Ethnicity_____*Language_____

*Social Security# _____-_____-_____ Drivers License#_____

Marital Status S _ D _ W _ Sep _ M _ Pharmacy Name: _____ Phone#_____

Pharmacy Address _____Employment Y____ N____

Employer _____Occupation _____

Emergency Contact

Name _____Relationship _____

Main Phone #_____Work Phone#_____

Referring Physician Name_____Phone #_____

Primary Care Physician_____Contact #_____

Primary Health Insurance Company_____

Policy Holder Name _____Relationship_____

Policy Holder's Date of Birth: _____SS#_____-_____-_____

Member ID #_____Group#_____

Secondary Ins. Co_____

Policy Holder Name_____ Relationship_____

Policy Holder Date of Birth_____ SS#_____-_____-_____

Member ID #_____Group #_____

----------*Auto Accidents Only*----------

Auto Insurance Company_____ Accident Date_____

Policy #_____Claim #_____

PIP Claims Adjustor_____Phone #_____

* Required Per Meaningful Use

David Campbell MDPA

NOTICE

ACKNOWLEDGMENT OF RECEIPT

HIPAA Privacy Policy

Patient Name: _____

I acknowledge that I have received a copy of the David Campbell, MD, PA, personal health information Privacy Policy.

X _____
Patient or Personal Representative Signature (circle one)

Date: _____

If personal representative signature appears above, please describe relationship to patient:

_____

_____

_____

David Campbell MDPA

PATIENT ACKNOWLEDGEMENT: OPIOID PAIN MEDICATIONS

_____ the patient, understand that I will only be prescribed OPIOID medication in the event that I have acute pain. Then, I will only be prescribed THREE days' worth of opioid medication or seven if medically necessary, as an exception. I acknowledge if my pain is not controlled adequately, the provider may refer me to a Pain Management specialist.

_____ _____

Patient Signature Date

David Campbell, M.D., P.A.
2055 Military Trail, Suite 312, Jupiter, FL 33458 Tel: 561-427-0860 Fax: 561-427-0870

3/24/2023(R)

FINANCIAL RESPONSIBILITY AND AUTHORIZATION

The following is our payment policy. Payment is accepted in the form of cash, checks, MasterCard, Visa, American Express. Your insurance carriers will be billed for out of network coverage unless exhausted or payment is otherwise denied. You are being provided health care services through our practice with the full expectation that you will pay for these services. We will request authorization for our services when your insurance carrier requires. It is your responsibility to be familiar with your plans benefits and restrictions. We will discuss your proposed treatment and provide non-binding cost estimates to you. If your insurance carrier denies any procedure, including surgical, office or hospital care, you will be responsible for these services. You will be asked to pay your co-insurance or full amount due at the time of service.

Returned checks are subject to an additional fee of $25.00. Accounts outstanding over ninety days will be subject to a monthly finance charge of 1.5%. We retain the right to send your account to a collection agency at our sole discretion. If this is necessary, you will be responsible for all fees and costs incurred as a result.

AUTOMOBILE ACCIDENT AUTHORIZATION

I, the undersigned patient, hereby direct my Personal Injury Protection (PIP) and/or Medical Payments Insurance Benefits Carrier (MPIBC) to make payments for medical services rendered to me by David Campbell, M.D., P.A. as a result of the motor vehicle accident that occurred on _____.

I authorize and direct my PIP and/or MPIBC to make any and all check or drafts payable solely to David Campbell, M.D., P.A. and forward same to the practice at 2055 Military Trail, Suite 312, Jupiter, FL 33458. My signature below is an indication that the medical services being billed were, in fact, rendered, to the best of my knowledge and belief. Further, the medical provider attests that such services were medically necessary and that the bill submitted for same is the reasonable and customary charge, as developed by David Campbell, M.D., P.A., using the practice's fee schedule, for said medical services.

I _____ hereby authorize _____ to make medical benefit
(Name of Insured Patient) *(Name of Insurance Carrier)*

payments otherwise payable to me for services rendered by the practice but not to exceed the charges of those services, payable to and mailed directly to: David Campbell, M.D., P.A., 2055 Military Trail, Suite 312, Jupiter, FL 33458.

Furthermore, I hereby IRREVOCABLY ASSIGN to David Campbell, M.D., P.A. the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and/or charges provided by the practice. Further, a photocopy of this executed document shall be sufficient in law as any original.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I hereby authorize the practice to furnish the patient's insurance company, attorney, or any representative thereof, with any and all information which may be requested regarding patient's past and present physical condition and treatment. I also authorize other health care providers to release information to the practice. I hereby authorize the physician in charge of the care of the patient to administer such medical care as may be deemed advisable in the diagnosis and treatment of this patient.

I authorize the patient's insurance company to pay directly to the group - David Campbell, M.D., P.A., any medical and/or surgical expenses payable under the terms of the contract. I agree that photocopies of this form will be valid.

I agree to the terms and policies stated and wish to be seen. IN WITNESS WHEREOF the undersigned have hereunto set their hands:

Name of Patient (Please Print): _____

Signature: _____ Date Signed: _____