UPS Central
205 Hospital Drive
Dover, OH 44622
330-343-7950

UPS
UNION PHYSICIAN SERVICES

PATIENT INFORMATION

Last Name: First Name: MI:	Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced	Spouse's Name: Spouse's Date of Birth:
Home Address: City: State: Zip:		Home Phone:
Date of Birth:	Age:	Sex: ☐ Male ☐ Female
Social Security #:	Home Email Address	Cell Phone:
Employer:	Employer Phone:	Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Other
Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other		
Referring Physician:	Referring Physician Phone:	Primary Language if other than English

PRIMARY INSURANCE

Insurance Company:	Policy #:	Group #:
Policyholder's Name:	Social Security #:	Date of Birth:
Address if Different from Patient:	City, State, Zip	Phone:

SECONDARY INSURANCE

Is patient covered by additional insurance: ☐ Yes ☐ No

Insurance Company:	Policy #:	Group #:
Policyholder's Name:	Social Security #:	Date of Birth:
Address if Different from Patient:	City, State, Zip	Phone:

EMERGENCY CONTACT

Name of person to contact in case of emergency:	Phone:	Relationship:

RELEASE OF INFORMATION

Name(s) to whom we may release info:	Phone:	Relationship:
Name(s) to whom we may release info:	Phone:	Relationship:

COMMUNICATION

Message may be left ☐ YES ☐ NO

Answering machine ☐ YES ☐ NO

Family Member ☐ YES ☐ NO Name(s) _____

ASSIGNMENT AND RELEASE OF BENEFITS

I authorize the release of any medical other information necessary to process any claims for medical services provided to me by my physician under Union Physician Services, LLC. I hereby authorize payment of medical benefits from my insurance company directly to my physician under Union Physician Services, LLC.

_____ _____ _____

Print Name Signature Date

UPS CENTRAL
PATIENT INTAKE FORM

WELCOME! Please answer EVERY question. It is very important we have complete information.

Name: _____ Date of Birth: _____

Visit Date: _____ Physician: _____

1. PATIENT'S MEDICAL HISTORY (If yes, check box)

- ☐ Ringing in ear
- ☐ Ear infections - Frequent
- ☐ Dizziness / fainting
- ☐ Hair loss
- ☐ Failing vision
- ☐ Eye infections
- ☐ Nose Bleeds
- ☐ Sinus trouble
- ☐ Sore throats- freq
- ☐ Hayfever / Allergies
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Chronic Cough
- ☐ Asthma / Wheezing
- ☐ Chest pain
- ☐ High Blood pressure
- ☐ Heart murmur
- ☐ Swollen ankles
- ☐ Leg pain walking
- ☐ Varicose veins
- ☐ Phlebitis
- ☐ Loss of appetite
- ☐ Difficulty swallowing
- ☐ Indigestion / heartburn
- ☐ Persistent nausea/ vomiting
- ☐ Peptic ulcers
- ☐ Abdominal pain - Chronic
- ☐ Scarlet fever
- ☐ Tuberculosis
- ☐ Herpes
- ☐ Other:

- ☐ Arthritis / Rhematism
- ☐ Osteoporosis
- ☐ Back pain - recurrent
- ☐ Bone fracture / joint injury
- ☐ Gout
- ☐ Foot pain
- ☐ Cold numb feet
- ☐ Rashes
- ☐ Hives
- ☐ Psoriasis
- ☐ Eczema
- ☐ Nervousness
- ☐ Depression
- ☐ Memory loss
- ☐ Moodiness - excessive
- ☐ Phobias
- ☐ Mental illness
- ☐ Lactose intolerance
- ☐ Prostate disease
- ☐ Sexual dysfunction
- ☐ Frequent infections
- ☐ Diptheria
- ☐ Tetanus
- ☐ Chicken pox
- ☐ Polio
- ☐ Mumps
- ☐ Measles
- ☐ Rubella
- ☐ Rheumatic fever
- ☐ Numbness / tingling
- ☐ Headaches - frequent

- ☐ Gall bladder
- ☐ Jaundice / hepatitis
- ☐ Change in bowel habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Diverticulosis
- ☐ Chrohn's
- ☐ Colitis
- ☐ Bloody / tarry stools
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Urine Infections - Frequent
- ☐ Blood in urine
- ☐ Urination > 2x overnight
- ☐ Painful urination
- ☐ Urine - Loss of control
- ☐ Urination decrease in force / flow
- ☐ Kidney stones
- ☐ Venereal disease
- ☐ Urethral discharge
- ☐ Chronic fatigue
- ☐ Weight loss - recent
- ☐ Anemia
- ☐ Bruise easily
- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Convulsions / Seizures
- ☐ Stroke
- ☐ Tremor / hands shanking
- ☐ Muscle weakness

FEMALES PLEASE COMPLETE:

Menstrual flow:
- ☐ Regular
- ☐ Irregular
- ☐ Pain / cramps

Days of flow: _____
Length of cycle: _____
1st day of last period: _____

Pain / bleeding during or after sex: ☐ Y ☐ N

Pregnant: ☐ Y ☐ N
Planning pregnancy: ☐ Y ☐ N

Pregnancies #: _____
Miscarriages #: _____
Abortions #: _____
Live births #: _____

Birth control method: _____

B.C. Pill name: _____

☐ Flushing / menopause

Date of last pap: _____
☐ Normal pap ☐ Abnormal pap

Last mammogram: _____
☐ Normal pap ☐ Abnormal

2.

FAMILY HISTORY	WHO?
Lung Disease	
Asthma	
Cancer	
What kind?	
Diabetes	
Thyroid Disease	
Heart Disease	
High Blood Pressure	
Kidney Disease	
Seizures	
Depression/Mental Disorder	

3. PATIENT'S HABITS

☐ Alcohol: type _____
Amount per week: _____

☐ Smokes (specify): _____ ☐ Years of smoking: _____
☐ Interested in stopping? _____

4. Living Will ☐ YES ☐ NO

5. Durable Power of Attorney for Healthcare ☐ YES ☐ NO Pharmacy: _____

6. MEDICATIONS

Medication Name	Dose	Route	Frequency

7. ALLERGIES _____

8.

SURGICAL HISTORY	
SURGERY	DATE

9. How did you hear about us? _____

UNION PHYSICIAN SERVICES

Financial Policy

I am pleased to provide your family's health care needs. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which you need to read and sign.

All patients or their legal representative shall complete an Information and Insurance form before seeing the doctor.

- *Full payment is due at the time of service.*
- *Co-payments are due at the time of service.*
- *Known coinsurance amounts are due at the time of service.*
- *We accept cash, checks, and credit cards. Returned checks will be subject to a $25.00 fee.*
- *Auto accident claims are your responsibility, payment is due at the time of service.*

REGARDING INSURANCE:

Presenting correct insurance information at the time of service is the patients/guarantor's responsibility. Failure to produce verification of guarantor insurance information will result in a patient status of "self pay" and payment will be due at the time of service.

Your insurance coverage is a contract between you and your insurance company. The Physician office is not a party to that contract. Not all service provided to you by the Physician office may be considered covered by your insurance company. It is your responsibility to know what service is covered under your policy and to check with your insurance company to verify whether the service to be provided is covered. As a standard procedure, the Physician office will bill your insurance company for the service rendered. The Physician office will attempt to identify and inform the patient when it becomes aware of non-covered services.

_____ Initials

I agree that, should the service not be covered or paid by my insurance company, I will be responsible for payment of the amount billed by the Physician office for the service rendered.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS:

The adult accompanying a minor is responsible for full payment at the time of service.

MISSED APPOINTMENTS:

As a courtesy to our other patients please contact the office with a 24 hour notice if you need to cancel an appointment. ***A fee of $25.00 will be entered to your account for each occurrence of "No Call - No Show."*** *If you fail to keep an appointment three times without calling to cancel, you shall be terminated as a patient.*

We understand that temporary financial problems may arise and affect timely payment on your account. Please contact our office promptly for assistance in the management of your account.

HIPAA PRIVACY DISCLOSURE AND USE ACKNOWLEDGEMENT

I acknowledge that I have received a copy or have reviewed the posted HIPAA Privacy Disclosure statement and use of medical information for services rendered to me by physicians under Union Physician Services, LLC.

_____ PRINT NAME

_____ SIGNATURE OF ADULT PATIENT/PARENT OR GUARDIAN

_____ DATE