UPS Family Health Center North
110 Dublin Drive, Suite A
Dover, Ohio 44622
Phone: 330-364-8038

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

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Fax: 330-364-4732

Patient Intake Form

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

Name: _____ Date of Birth: _____

Visit Date: _____

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. IT IS VERY IMPORTANT YOU ANSWER EVERY QUESTION! PLEASE ANSWER YES OR NO.

Medical Problems of other family members (not Including the child)	*Have any blood relatives had:*	*If yes, who? Specify relationship to the child (ex.- grandmother, mother, brother, etc)*	*Medical Problems of other family members (not Including the child)*	*Have any blood relatives had:*	*If yes, who? Specify relationship to the child (ex.- grandmother, mother, brother, etc)*
Birth defects	☐YES ☐NO		Thyroid Disease	☐YES ☐NO	
Genetic defects	☐YES ☐NO		Heart Disease / Problems	☐YES ☐NO	
Mental retardation	☐YES ☐NO		Anemia / Blood Disorders	☐YES ☐NO	
Allergies	☐YES ☐NO		High Blood Pressure	☐YES ☐NO	
Lung disease	☐YES ☐NO		Kidney Disease / Problems	☐YES ☐NO	
Asthma	☐YES ☐NO		Rheumatic Fever	☐YES ☐NO	
Bone / joint disorder	☐YES ☐NO		Tuberculosis (TB)	☐YES ☐NO	
Rheumatoid Arthritis	☐YES ☐NO		Seizures / Convulsions	☐YES ☐NO	
Muscle Disorder	☐YES ☐NO		Mental Disease / Disorder	☐YES ☐NO	
Skin Disease	☐YES ☐NO		Venereal Disease	☐YES ☐NO	
Eye or Ear Disorders	☐YES ☐NO		HIV/AIDS	☐YES ☐NO	
Cancer	☐YES ☐NO		Other:	☐YES ☐NO	
Diabetes	☐YES ☐NO				

3. PATIENT'S HABITS

☐ Alcohol: type _____
Amount per week: _____

☐ Diet: No Restrictions _____

☐ Diet: low salt _____

☐ Diet: Low Fat _____

☐ Diet: Diabetic _____ calories

☐ Other _____

☐ Smokes (specify): _____

☐ Years of smoking: _____

☐ Interested in stopping?_____

☐ Exercise routine: _____

☐ Sleep, / difficulty falling asleep
☐ Continuity disturbances
☐ Early Morning Awakening
☐ Daytime drowsiness/fatigue
☐ Other:

☐ Coffee / cups per day: _____

☐ Other caffeine use:

_____

_____

4. Living Will ☐ YES ☐ NO

5. Durable Power of Attorney for Healthcare ☐ YES ☐ NO

6. MEDICATIONS

Medication Name	Dose	Route	Frequency

7. ALLERGIES _____

8. SURGICAL HISTORY _____

_____

_____

_____

_____

UNION PHYSICIAN SERVICES
AUTHORIZATION FOR RELEASE OF INFORMATION

UPS
UNION PHYSICIAN SERVICES

UPS Family Health Center North
110 Dublin Drive, Suite A
Dover, Ohio 44622
Phone: 330-364-8038
Fax: 330-364-4732

Patient's Name: _____ Social Security #: _____

Date of Birth: _____ Date of Treatment: _____

1. I authorize Name: _____

Address: _____

To: ☐ Release records to
☐ Obtain records from
☐ Exchange information with

Name: _____

Address: _____

I authorize the release of: (check all that apply)

☐ Mental Health Information ☐ Drug and Alcohol Information

AIDS or HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. _____ (Initials) Do Not Release

Requested Records to Release:

☐ DISCHARGE SUMMARY
☐ HISTORY AND PHYSICAL
☐ OPERATIVE REPORTS
☐ PATHOLOGY REPORTS
☐ RADIOLOGY REPORTS
☐ X-RAY FILM
☐ LABORATORY REPORTS
☐ CARDIOPULMONARY REPORTS
☐ PHYSICIAN'S ORDERS/PROGRESS NOTES
☐ CONSULTATION REPORTS
☐ OTHER: _____
☐ COMPLETE MEDICAL RECORD (do not check this unless entire record is required)

2. The above information is released for the following purpose and that purpose only. Any other use is forbidden:

_____ Insurance or other third party reimbursement
_____ Continuity of medical care
_____ Pending legal action
_____ Other (specify) _____

3. A copy of this authorization made by duplicating process shall be valid for all purposes as this original signed by me. I understand that this Authorization is effective for a period of 90 days from the date of the signature, unless otherwise specified below. No time frame may exceed one year after the date of signature. I understand that I have the right revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. If applicable, specify other expiration date/event here _____

BY SIGNING BELOW I CERTIFY THERE IS NO COURT ORDER IN EFFECT WHICH LIMITS OR PROHIBITS MY ACCESS TO THESE RECORDS.

_____ _____ _____
(Signature) (Date) (Time)

Signed: Patient ☐ Spouse ☐ Guardian ☐ Other: _____

A legal document naming guardian or executor of estate must accompany authorization where applicable (proof of legal executor of estate of those patients expired, or legal proof of guardianship).

Form No. 8922-005Q (1/17) Union Hospital, Dover, Ohio 44622