Union Physician Services
East Ohio Orthopaedics
167 Union Ave.
Dover, OH 44622

HEALTH HISTORY

UPS
UNION PHYSICIAN SERVICES

Please complete the following Information for review by your provider.

Name: _____ Birth Date: ____/____/____ Acct #: _____

Height: _____ Weight: _____ Race: _____ Sex: ☐ M ☐ F Dominant Hand: ☐ Right ☐ Left

Referring Doctor: _____ Family Doctor: _____

Patient Medical History

☐ Heart Trouble	☐ Gout	☐ Bleeding	☐ Anemia	☐ AIDS
☐ High Blood Pressure	☐ Seizures	☐ Serious Injuries	☐ Stomach Ulcers	☐ Hepatitis
☐ Stroke	☐ Sleep Apnea	☐ Lung Disease	☐ Liver Trouble	☐ Other:
☐ Diabetes	☐ Kidney Trouble	☐ Asthma	☐ Thyroid Trouble	_____
☐ Arthritis	☐ Osteoporosis	☐ Phlebitis	☐ Cancer	_____

Previous Surgeries: ☐ None Hospital/Date Previous Surgeries: Hospital/Date

Problems with Anesthesia? ☐ Yes ☐ No Describe: _____

Family Medical History (Mark if any of these run in your family)

☐ Heart Trouble	☐ Stroke	☐ Arthritis	☐ Seizures	☐ Kidney Trouble	☐ Alcoholism
☐ High Blood Pressure	☐ Diabetes	☐ Gout	☐ Mental Illness	☐ Bleeding	☐ Cancer

Patient Social History

Married / Single Do you live alone? ☐ Yes ☐ No If no, who do you live with _____

# of children: _____ Do you exercise regularly? ☐ Yes ☐ No Describe: _____

Tobacco Use? ☐ Yes ☐ No Type: ☐ Cigarettes ☐ Chew # of packs per day ____ # of years used: ____

Alcohol Consumption? ☐ Yes ☐ No # of drinks/week: _____ History of Alcoholism? ☐ Yes ☐ No

Recreational/Drug Usage: Yes No Type/Amount/How Often: _____

Review of Systems *(recent or current condition only)*

☐ Weight Change ☐ Fever / Chills ☐ Night Sweats ☐ Poor Appetite	☐ Ear Pain / Ringing ☐ Nosebleeds ☐ Hoarseness ☐ Difficulty Swallowing ☐ Tooth/Gum Trouble	☐ Shortness of Breath ☐ Cough	☐ Incontinence ☐ Urinary Frequency ☐ Urinary Burning ☐ Irregular Periods ☐ Vaginal Discharge ☐ Pregnant	☐ Numbness ☐ Weakness ☐ Frequent Headaches ☐ Seizures ☐ Blackouts
☐ Rash		☐ Stomach Pain ☐ Nausea / Vomiting ☐ Frequent Diarrhea ☐ Frequent Constipation ☐ Blood in Stool		☐ Chronic Infection _____
☐ Insomnia ☐ Depression ☐ Anxiety	☐ Visual Changes ☐ Chest Pain ☐ Abnormal Heartbeat		☐ Joint/Limb ☐ Swelling Joint ☐ Pain ☐ Lumps/Masses ☐ Backache	

Patient Signature: _____

Date: _____

Notes _____

Physician Reviewed:
Initials: _____ Date: _____

TURN OVER â

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MEDICATION RECORD

Please complete the following Information for review by your provider.

Name: _____ Birth Date: ____/____/____ Acct #: _____

Today's Date: _____ Pharmacy: _____

Medications

Allergies to Medications: ☐ None ☐ Yes, list: _____

Latex Allergy/Sensitivity? ☐ Yes ☐ No _____

Metal Allergy? ☐ Yes ☐ No _____

Medications you currently take (including over the counter medications, vitamins, herbs, & prescribed drugs):

Medication	Dosage	Medication	Dosage	Medication	Dosage

☐ See separate medication list

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