

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**

- |  |   |   |  |                                       |
|--|---|---|--|---------------------------------------|
| <input type="checkbox"/> Heart Trouble       | <input type="checkbox"/> Gout           | <input type="checkbox"/> Bleeding         | <input type="checkbox"/> Anemia          | <input type="checkbox"/> AIDS         |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures       | <input type="checkbox"/> Serious Injuries | <input type="checkbox"/> Stomach Ulcers  | <input type="checkbox"/> Hepatitis    |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Sleep Apnea    | <input type="checkbox"/> Lung Disease     | <input type="checkbox"/> Liver Trouble   | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Thyroid Trouble | _____                                 |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Osteoporosis   | <input type="checkbox"/> Phlebitis        | <input type="checkbox"/> Cancer          | _____                                 |

Previous Surgeries: <input type="checkbox"/> 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)**

- |  |                                   |                                    |   |   |                                     |
|--|-----------------------------------|------------------------------------|---|---|-------------------------------------|
| <input type="checkbox"/> Heart Trouble       | <input type="checkbox"/> Stroke   | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Seizures       | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout      | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Bleeding       | <input type="checkbox"/> 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)**

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

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Notes \_\_\_\_\_

Physician Reviewed: Initials: _____ Date: _____
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Union Physician Services  
East Ohio Orthopaedics  
167 Union Ave.  
Dover, OH 44622

## 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

**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.

\_\_\_\_\_ I agree that, should the service not be covered or paid by my insurance company, I will be responsible for payment of  
Initials 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