Union Internal Medicine Specialties, Ltd.
515 Union Ave, Suite 187 Dover, Ohio
New Patient Registration Form

Appointment Date:____________________@______________With:________________________

IT IS IMPORTANT TO ARRIVE 20 MINUTES BEFORE YOUR APPOINTMENT YOU WILL NEED TO BRING YOUR INSURANCE CARD AND PHOTO ID. YOU WILL REGISTER WITH THE FRONT DESK AND A NURSE/MEDICAL ASSISTANT WILL TALK TO YOU PRIOR TO SEEING YOUR PROVIDER.

First Name: ______________________________ M.I.:__________ Last Name:____

Birth date: ____________Social Security Number: ________________________ Gender: M / F Race/Ethnicity: _____________

Marital Status: Married / Single / Separated / Divorced/ Partner / Married same sex/ Partner same sex / Other_______________

Patient Address: ____

Street *City* *State* *zip*

Email____

Home # ______________________________ Cell #__________________________ Alternative #___________________________

Employment Status: Full time / Part time / Unemployed / Retired / Other_______________Occupation______________________________

Employer ____________________________________Work Telephone: ____

Emergency Contact: ____

Name *Relationship* *Telephone Number needs to be different from yours*

Insurance Information

Primary Insurance: ____

Policy Number____________________________________ **Group Number**____

Primary Card Holder (*Husband, Wife, Parent, Self*)____

First name *last name* *Middle Initial*

Primary Card Holder's DOB: _____________________ Relationship to patient: ____

Primary Card Holder's Employer: ____

Secondary Insurance: ____

Policy Number____________________________________ **Group Number**____

Primary Card Holder (Husband, Wife, Parent, Self) ____

First name *last name* *Middle Initial*

Primary Card Holder's DOB: _____________________ Relationship to patient: ____

Primary Card Holder's Employer: ____

Patient/Responsible Party Signature____Date:___________________________

UIMS HEALTH HISTORY

Name: ____ Birthdate: ____________________

Check if you are CURRENTLY experiencing any of the following symptoms:

General	Cardiovascular		Men Only
☐Fever	☐Chest pain	☐Rectal bleeding	☐Erectile dysfunction
☐Chills	☐High blood pressure	☐Hemorrhoids	☐Lump in testicle
☐Sweats	☐Irregular/rapid heartbeat	☐Difficulty swallowing	☐Penis discharge
☐Headaches	☐Swelling in ankles	**Urinary**	☐Sore on penis
☐Forgetfulness	☐Dizziness	☐Recurrent infections	☐Reduced urinary stream
☐Weight Loss	☐Varicose veins	☐Frequency	☐Enlarged prostate
☐Weight Gain	**Lungs**	☐Burning	**Women Only**
☐Insomnia	☐Cough	☐Incontinence	☐Abnormal pap smear
☐Fatigue	☐Coughing blood	☐Retention	☐Irregular periods
☐Depression	☐Shortness of breath	**Musculoskeletal**	☐Breast lump
☐Anxiety	☐Wheezing	☐Joint pain	☐Extreme menstrual pain
☐Excessive thirst	☐Chest congestion	☐Muscle pain	☐Hot flashes
Eye, Ear, Nose, Throat	**Gastrointestinal**	☐Leg cramps	☐Nipple discharge
☐Vision changes	☐Poor appetite	☐Swelling	☐Painful intercourse
☐Hearing loss	☐Bloating/gas	☐Numbness	☐Vaginal discharge
☐Earache	☐Bowel changes	☐Tingling	**Other**
☐Ringing in the ears	☐Constipation	☐Tremors	
☐Hay fever	☐Diarrhea	☐Back pain	
☐Nosebleeds	☐Indigestion	**Skin**	
☐Sinus problems	☐Reflux/heartburn	☐Bruising	
☐Hoarseness	☐Nausea	☐Hives	
☐Bleeding gums	☐Abdominal pain	☐Rash	
☐Snoring	☐Vomiting	☐Change in moles	
		☐Nonhealing ulcers	

Check if you have a history of any of the following conditions:

☐Alcoholism	☐Cataracts	☐Gout	☐Mental illness	☐Shingles
☐Anemia	☐Chicken pox	☐Heart disease	☐Migraines	☐Stomach ulcers
☐Arthritis	☐Circulation problems	☐Hepatitis	☐Multiple sclerosis	☐Stroke
☐Asthma	☐COPD/emphysema	☐Herpes	☐Osteoporosis	☐Thyroid problems
☐Anxiety	☐Colon polyps	☐High blood pressure	☐Pneumonia	☐Tuberculosis
☐Atrial fibrillation	☐Depression	☐High cholesterol	☐Polio	☐Venereal disease
☐Bleeding disorder	☐Diabetes	☐HIV	☐Prostate problems	☐Other ____________
☐Blood clots	☐Diverticulitis	☐Kidney disease	☐Restless leg	☐Other ____________
☐Breast lump	☐Fibromyalgia	☐Kidney stones	☐Rheumatic fever	☐Other ____________
☐Cancer ____________	☐Glaucoma	☐Liver disease/cirrhosis	☐Seizures	☐Other ____________

Check any surgeries you have had and fill in approximate date:

☐Appendix ______________	☐Cataract ________________	☐Heart Stent ______________	☐Tonsils__________________
☐Back ___________________	☐D&C ___________________	☐Hip replacement __________	☐Tubal___________________
☐Breast _________________	☐Gallbladder _____________	☐Hysterectomy ____________	☐Thyroid _________________
☐Carpal tunnel ___________	☐Hernia _________________	☐Knee replacement__________	☐ ______________________
☐Carotid ________________	☐Hemorrhoids ____________	☐Mastectomy ______________	☐ ______________________
☐C-section_______________	☐Heart bypass ____________	☐Pacemaker _______________	☐ ______________________

Check if you have had any of the following and fill in approximate date:

Health Maintenance	Immunizations	Women Only	Men Only
☐Bone density______________	☐Pneumovax _____________	☐Mammogram ____________	☐PSA ____________________
☐Colonoscopy ______________	☐Prevnar13 ______________	☐Pap Smear_______________	
☐Stress Test_______________	☐Zostavax_________________		
	☐Shingrix _________________		
	☐Flu _____________________		

Health History Continued...

Name: ________________________

D.O.B: ________________________

Family History:

Relation	Age	Living/Deceased	Major Medical Conditions	Check if any other blood relatives have any of the following conditions:	
				Condition	**Relationship to you**
Father		☐L / ☐D		☐Asthma	
Mother		☐L / ☐D		☐Arthritis, gout	
Brothers		☐L / ☐D		☐Cancer	
		☐L / ☐D		☐Diabetes	
		☐L / ☐D		☐Heart disease	
		☐L / ☐D		☐High Blood Pressure	
Sisters		☐L / ☐D		☐Stroke	
		☐L / ☐D		☐Kidney disease	
		☐L / ☐D		☐TB	
		☐L / ☐D		☐Other	

Social History:

Relationship Status (circle):	Single Married Divorced Separated Widowed Partner	
Sexual Orientation (Circle):	Straight Gay Lesbian Bisexual Transgender	
Number of children:	Boys _____ Girls _____	
Highest level of education (circle):	Grade school High School Trade School College Graduate School	
Occupation:	____________________________________	
Do you have a living will:	☐Yes ☐No	
Medical Power of Attorney:	____________________________________	
Smoking Status:	☐Never a Smoker ☐Former Smoker ☐Current Smoker	
	If Former Smoker:	Age Started Smoking _____ Age Quit Smoking _____ Average amount smoked per day _____
	If Current Smoker:	Age Started Smoking _____ Average amount smoked per day _____
Alcohol Use:	☐Never ☐Former ☐Rare ☐Social/Weekends ☐Daily	
	If Former Drinker:	Age started drinking: _____ Age quit drinking: _____ Average consumed per day: _____
	If Current Drinker:	How many drinks per day on average: ☐Beer _____ ☐Liquor _____ ☐Wine _____
Drug Use:	☐Never ☐Former ☐Current: type/frequency __________________________	
Caffeine Use:	☐None ☐Coffee _____ cups/day ☐Tea_____ cups/day ☐Pop _____ cups/day	

Health History Continued...

Name: ________________________
D.O.B: ________________________

Medication Allergies: ____

MEDICATIONS (Please list all meds including prescriptions, over the counter meds, supplements and vitamins)

Medication	Dosage	Frequency

All Insurance Authorization and Assignment

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all of the information on this form and have completed all the answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any change in my health insurance status of the above information.

______________________________ ______________________

Signature of Patient or Responsible Party (Relationship) Date

FOR MEDICARE PATIENTS

Statement to Permit Payment of Medicare Benefits to Provider, Physician and Patient.

I certify that the information given by me in applying for payment under Title VIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Health Care Financing Administration, or its intermediaries or carries, any information needed for this or related Medicare claim. I request that pay of authorized benefits be made on my behalf. I assign the benefits payable to covered Medicare services to physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

I request that payment under the medical insurance program be made either to me or to Union Internal Medicine Specialties on any bills for services rendered me by Union Internal Medicine Specialties, Ltd.

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Signature of Patient

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Date Signed

____

Health Insurance Claim Number