Welcome

We would like to take this opportunity to welcome you to
Newcomerstown Union Physicians Services
60881 County Rd 9
Newcomerstown, Ohio 43832
740-498-9828

Please complete and sign the enclosed paperwork and bring them with you to your appointment on _____

You will need to arrive at the office 30 minutes prior to your appointment time and you will need to have the following with you to be seen:

- Insurance card (s)
- Drivers License
- Guarantor information including social security number
- Co-payment if applicable
- Current list of medications you are taking
- Completed New patient forms

Please contact us with any questions or concerns you may have.
Thank you for giving us the opportunity to serve you.

Dr. Jeffrey Burrier
Dr. Christopher Coulson
Dr. Denise Miller

Newcomerstown Union Physician Services
60881 County Rd. 9
Newcomerstown, Ohio 43832
Phone: 740-498-9828
Fax: 740-498-9761

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

NEWCOMERSTOWN UNION PHYSICIAN SERVICES
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 _____

_____

_____

_____

_____