UPS Regional Surgical Specialties
400 Medical Park Drive, Suite 203
Dover, Ohio 44622
(330) 343-3433

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 #:	Primary Language if other than English	Cell Phone:
Employer:	Employer Phone:	Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Other

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other

Referring Physician:	Referring Physician Address:	Referring Physician Phone:

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

UPS Regional Surgical Specialist

Robert Levitt M.D.
Joseph Zemis M.D.
Marcus Cox M.D.

Phone: (330)343-3433
Fax: (330)343-3449

Patient intake form

Name_______________________________ DOB__________ Pharmacy____________________________

Living will ☐Yes ☐No Durable Power of attorney for Healthcare- ☐Yes ☐No

Referring Physician_____________________________

Current Symptoms/Reason for Visit : Length of time:

1.	
2.	
3.	

What medications are you currently taking?	Dose	Frequency

Please list any allergies & reaction to medication:

Social History

Do you use any of the following -Please mark all that apply:

	Yes	Never	Quit	Amount per day
Drugs				
Alcohol				
Tobacco				
Caffeine				

Name____________________________

Past Medical History

Condition	Yes	No	Condition	Yes	No
Diabetes			Lung Cancer		
High blood pressure			Colon Cancer		
Heart disease			Cancer________________		
Kidney Failure			Asthma		
Stroke			Respiratory Problems		
DVT			Blood disorder		
Anxiety/Depression			Jaundice		
Thyroid disease			Other:		
Arthritis					
Colon Cancer					
Breast Cancer					

Family History	Major Illnesses	Alive or Deceased
Father		
Mother		
Brother		
Sister		
Children		
Other		

Past Surgical History

Surgery	Yes	No			
Appendectomy			Other:		
Tonsillectomy					
Gallbladder(Cholecystectomy)					
Hernia					
Cardiac Bypass					
Spine surgery					
Breast surgery					
Bowel Surgery					
Joint Replacement:					

Number of pregnancies: _______ **Number of children you have: ________**

Patient signature :___________________________________ Date:__________________