1420 Locust St. Philadelphia, PA 19102

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www.myDocUC.com

PATIENT INFORMATION

Name (First, Middle, Last)

Address

City State Zip

Sex ☐M ☐F

Date of Birth Age

Marital Status ☐S ☐ M ☐D ☐W

Race ☐American Indian or Alaska Native
☐Asian
☐Black or African American
☐Native Hawaiian or Other Pacific Islander
☐White

Ethnicity ☐Hispanic or Latino
☐Not Hispanic or Latino

Preferred language

Home Phone

Cell Number Email

Social Security Number

Responsible Party or Parents Name (if minor) Guar. BD

Patient's employer or parent occupation

Work Phone

Spouse's Name

Employer (Spouse's)

Work Phone (Spouse's)

Cell Number Email

In case of emergency who should we contact?

Name

Relationship

Address

City State Zip

Telephone - Day Telephone – Evening

Cell Number Email

Name

Referring Doctor/Source

Information concerning your care provided by this

center will be forwarded to your referring doctor/source unless otherwise specified

PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST

Primary Insurance Carrier

_____
Insurance Company Name

_____
Address

_____
City State Zip

_____
Phone Policy Number

_____
Group Number/Name Insured Name & DOB

Patient's relationship to insured:
☐Self ☐Spouse ☐Dependent ☐Other

Secondary Insurance Carrier

_____
Insurance Company Name

_____
Address

_____
City State Zip

_____
Phone Policy Number

_____
Group Number/Name Insured Name & DOB

Patient's relationship to insured:
☐Self ☐Spouse ☐Dependent ☐Other

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT; AND THAT YOU SIGN A FINANCIAL RESPONSIBILITY STATEMENT.

I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance and other agency reimbursements to this center.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

_____
Signature Date

PATIENT HISTORY

Is this a workers comp claim? _____ Date of Injury _____

Workers Comp. Billing Address _____
Medication Allergies: _____
Other Allergies: _____

Please make an (x) by any of these conditions you may have or have had in the past:

_____Heart disease	_____Liver disease	_____Lumbar spine disorder
_____High blood pressure	_____Bowel disease	_____Severe headaches
_____High cholesterol	_____Cancer (past or present)	_____Tuberculosis/TB
_____Lung disease	_____Anemia or other blood disease	_____Muscle disease
_____Diabetes	_____Blood clots	_____Mental health problems
_____Hypoglycemia (low Glucose)	_____Bleeding tendency	_____Depression
_____Thyroid disease	_____Stroke	_____Chronic skin disease
_____Stomach disease	_____Seizures	_____Sleep apnea
_____Kidney, bladder or prostate disease		_____Nerve impairment
_____Joint replacement	_____Cervical spine disorder	Other_____

Past Medical Conditions

Approximate Date: _____ Condition:_____
Approximate Date: _____ Condition:_____
Approximate Date: _____ Condition:_____
Approximate Date: _____ Condition:_____

Current Medications (includes non-prescription products)

1) _____ 2) _____ 3) _____
4) _____ 5) _____ 6) _____
7) _____ 8) _____ 9) _____

Personal Habits

Do you drink caffeinated beverages (coffee, tea, soda)? _____Daily intake? _____
Do you drink alcoholic beverages? _____ If yes, _____ drinks/ □day, □week, □month
Do you smoke or chew tobacco? _____ If yes, _____ /day, _____ years of use
If no, any prior nicotine use? _____ years

Orthopedic or Other Major Surgeries
Review of Systems Do you have If Yes, Explain

Approximate Date: _____ Surgery:_____
Approximate Date: _____ Surgery:_____
Approximate Date: _____ Surgery:_____
Approximate Date: _____ Surgery:_____

Patient Name: _____Birthdate: _____ Today's Date:_____

Special Considerations

_____Legally blind _____Hearing impaired _____Need handicap facilities
_____Pregnant _____Attempting Pregnancy _____Smoker ____Packs per day
_____Substance abuse Describe: _____
_____Alcohol abuse Describe: _____
_____None of the above

Activity Level

_____Competitive athlete _____Well-trained/frequent Sports _____Occasional sports
_____No Sports

What would you like your physician/team to accomplish today? (Mark all that apply)

_____Accurate diagnosis _____Nutritional plan _____Medication/Injection
_____Physical therapy _____Surgery plan if necessary _____Disability information
_____Healthy exercise plan _____Alternative therapy plan (May include acupuncture, massage, manipulation)
_____Other _____

Review of Systems	**Do you have**		**If Yes, Explain**
Skin	Rashes, bumps, lumps, open sores, wounds	No Yes	
Head/Eyes/Ears/ Nose/Throat	Failing eyesight, falls, seizures, vertigo, blackouts, hoarseness, nasal congestion	No Yes	
Lungs	Unexpected breathlessness, wheezing (day or night), blood in sputum, or chronic cough	No Yes	
Heart	Chest pain, irregular heart beat, pacemaker	No Yes	
Bowels	Blood in stool, change in bowel habits, worrisome indigestion or abdominal pain	No Yes	
Bladder/Kidney	Trouble urinating, infections, blood in urine	No Yes	
Emotional	Any mental health problems, Depression, self-harm or suicidal thoughts	No Yes	
Musculoskeletal	Arthritis, fractures injuries, muscle weakness or cramping	No Yes	