Fairfield INTERNAL Medicine, Inc.

135 N. Ewing St., Suite 305, Lancaster, OH 43130
Phone 740-681-9447 * Fax 740-681-9966
www.fairfieldinternal.com

NEW PATIENT APPLICATION

Please fill in and return completed form to Fairfield Internal Medicine, Attn: Hallie

Patient's Name ____ DOB __________________

Address ____

SS# __________________ __Male ___Female ___Married ___ Single ___ Widowed ___ Divorced

Phone# ___________________________ Referred by _______________________________

Physician Requested: ___ Dr. Abidin ___ Dr. Nickison ___ Dr. Murray ___________________

___ First Available

Preferred Appointment Time: ___ Morning ___ Afternoon Day of Week _____________

Please send a copy of your insurance card with this application

Primary Insurance ____________________________________

Secondary Insurance __________________________________

Cardholder/Member Name _______________________________ DOB _____________

Are you on Disability? ___ Yes ____ No

Do you have any Worker's Compensation related medical issues? ___ Yes ____ No

Medical Conditions ____

____

Current Medications ____

____

[USE BACK OF APPLICATION IF NEEDED]

Current Primary Care Doctor ____

Doctors you've seen in the past 5 years _______________________________________

____

Have you ever been dismissed by a doctor? ___ Yes ___ No

If yes, reason why and when: ____

____

How did you hear about our office? ___ Newspaper ___ Website ___ Friend ___________________________ Other

Patient Signature ____

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FOR OFFICE USE ONLY: ☐ New Patient Info Sent ☐ Patient to Pick Up

Appointment Date, Time, Doctor: ____
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