CENTRAL OHIO PRIMARY CARE

Fairfield Medical Associates
P: 740-687-8600 F: 740-475-0598

ALL FIELDS MUST BE COMPLETED BEFORE REQUEST WILL BE SUBMITTED TO DOCTOR

NEW PATIENT REQUEST FOR DR_____DATE_____

Patient Name_____

Female [ ] Male [ ] DOB_____ Social Security Number: _____

Address_____City/State/Zip_____

Phone # (Home) _____ (Cell) _____

Primary Insurance (where claims are submitted) _____

Member/Billing ID #_____Group #_____Co-Pay $_____

Claims Address_____

Guarantor (name of primary insurance carrier if not Medicaid, Caresource, Medicare)

Name_____ DOB_____

Address_____

Phone # (Home) _____ (Cell) _____

Secondary Insurance (where claims are submitted) _____

Member/Billing ID #_____Group #_____

Guarantor (name of primary insurance carrier if not Medicaid, Caresource, Medicare)

Name_____ DOB_____

Address_____

Phone # (Home) _____ (Cell) _____

Guarantor (name of primary insurance carrier if not Medicaid, Caresource, Medicare)

Name_____ DOB_____

Diagnosed Medical Conditions_____

Names of Specialists Seen_____

Medications_____

Previous Physician_____ Reason for Transfer_____

Office Use Only:

Doctor's Signature _____Approved to schedule in _____time slot

_____Do Not Schedule Patient

Staff completing Form: _____ **Date completed**: _____

Insurance verified on: _____ **Given to provider on**: _____

Notes _____

Patient Informed by _____ Date _____