Family Physicians of Lima

2875 W. Elm St.
Lima, OH 45805
(419) 991-7805

We are taking new patients as our schedule allows, however, we need some information from you first. Please complete the following and mail back to our office. Thank you for considering Family Physicians of Lima as your health care provider.

Today's Date: _____

**We are <u>not</u> accepting new patients who use tobacco.*
**We are <u>not</u> accepting new patients who are taking narcotic or controlled drugs.*
**We are <u>not</u> Medicaid Managed Care providers; therefore we are not accepting new Medicaid patients.*
**We _____ are _____ are not accepting new Medicare patients.*
Do not apply if any of above apply to you.

Patient's Name: _____ Male Female

Email address: _____

Patient's Address: _____
Address City State Zip Code

County: _____ Home #: _____ Cell # _____ Work # _____

Patient's Birthdate: _____ Social Security # _____ S M W D

Other family members that we see or will see?: _____

Primary Insurance Company: _____

Policy Holder's Name: _____ Relationship: _____

Policy Holder's DOB: _____ Effective Date: _____

Employer's Name: _____ Co-pay $_____

If you have Secondary Insurance, please inform the front receptionist.

Person responsible for bill if other than yourself: _____

Relation: _____ *Best # to reach responsible party :* _____

Address of responsible party: _____

PATIENT HISTORY

Past medical history: _____

_____

_____

Hospitalizations within the last 5 years: _____

_____

Allergies: _____

(OVER)

Do you have a family history of (family = Mother, Father, Siblings): "**X**" all that apply

_____ Diabetes _____ Cancer _____ Heart disease _____ Stroke

Last pap test: _____ Last mammogram: _____

Last colonoscopy: _____ Last DEXA scan: _____

Have you ever smoked? NO _____ YES _____ (Year quit: _____)

Doctor you wish to see here? (please circle) **Dr. Karri Krendl** **Dr. Tracy Sharp**

Do you have other family members that are patients here at Family Physicians of Lima? If yes, what are their name(s)? Or will we only be seeing you? _____

Pharmacy you use: _____

Current Medications:	Dose:	Reason for taking:

How did you hear about our practice? _____

Date received back in office: _____

Please note, if you are accepted as a new patient, we will schedule you a visit to get established. We do attempt to call you and remind you of that new patient appointment. Please list a number that we may contact you at or leave a voice mail.

If you fail to show for your appointment, you will be declined as a new patient. Thank you.