



HURON COUNTY GENERAL HEALTH DISTRICT

180 Milan Avenue Suite 8
Norwalk, OH 44857
419-668-1652
419-668-5423 FAX
1-888-694-2443 Toll-Free

Timothy Hollinger MPH

Family Health Clinic Application

Please complete the information below. Return the completed form to the Huron County General Health District. Your application for medical care will be reviewed by the Medical Staff. You will be notified of your acceptance as a patient with the Family Health Clinic or not at the contact information you list, within 10 working days of our department receiving the completed application.

Name : _____ Date of Birth: _____

Social Security Number: _____ Best Phone Number to reach you : _____

Mailing Address: _____ City: _____

Who referred you to this clinic? How did you learn about us? _____

Do you have any family members treated here? Their name: _____

Have you been a patient here before? No ___ Yes ___ What was your name then? _____

What is the main reason you want to come to the clinic? _____

What is the name of your last family doctor or clinic? _____

What is the address and phone number of that doctor or clinic? _____

Why did you leave that doctor or clinic? _____

When were you last seen by that doctor or clinic?: _____

Please list the names of any specialist physicians you see: _____

I am willing to consent to release of my previous medical records for review by this clinic: Yes ___ No ___

Where do you work?: _____

Work Address: _____ Work Phone: _____

How long have you worked there?: _____ What do you do there? _____

Please circle all that apply: I have: **Medicaid** **Medicare** **private insurance** **No insurance coverage**

Office use only:	Date Application Received:	
	Accepted or Denied?	
	Applicant notified (date):	

MEDICAL HISTORY:

If more room is needed for any information, please use the back of the page

Illnesses/Injuries you have been treated for (include ER visits within the past 3 months):

Illness/injury type	Date	Doctor or hospital name

Medications you take or are supposed to take

Medicine name	Date last taken
ALLERGIES:	

I have been ADMITTED to the hospital OVERNIGHT for:

Reason	Date	Hospital

I have had these surgeries:

Surgery	Date

Your signature: _____ **Today's date:** _____