Lakeshore Internal Medicine and Pediatric Associates
Patient Information Sheet
(This form must be completed entirely)

Who is your primary care physician?
Greg Schrotenboer, MD Tricia Miller, MD Brian Drozdowski, MD Aaron Tolan, MD
(Circle One Please)

Patient Information

Last Name:_____
First Name:_____
Middle Initial:_____
Address 1:_____
Address 2:_____
City:_____State:_____
Zip Code:_____
Social Security No:_____
Marital Status:_____
Email Address:_____
Preferred Pharmacy and location:_____
_____

Home Phone: (_____) _____-_____
Leave Message: Y N Brief/Extended (circle one)
Cell Phone: (_____)_____-_____
Leave Message: Y N Brief/Extended (circle one)
Work Phone: (_____)_____-_____

Gender (circle one): Male Female

Date of birth:_____

Race **(circle one):** American Indian / Asian / Hispanic
African American / Caucasian / Other

Ethnicity **(circle one):** Hispanic / Non-Hispanic /
Prefer Not to Say

Language:_____

APPOINTMENT REMINDERS: (Circle one)
TEXT AUTOMATED CALL BOTH

**For your protection, and in compliance with Federal Regulatory Requirements to safeguard against identity theft you will be required to provide us with a valid photo ID with your current address and your insurance card at every visit. We will scan this into our system in order to verify your identity in respect to any request for your medical information and submitting of information to your insurance carrier for payment.

If patient is minor (under age 18):
Father's Name:_____
Fathers's Work Number :_____

Mother's Name: _____
Mother's Work Number:_____

Today's Date_____

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

By signing below I acknowledge that I am aware of this office's Notice of Privacy Practices Form which is posted in the waiting area. I am agreeing to release my protected health information for the purpose of further treatment and/or health care operation.

Signature_____ Relationship_____

Release of Medical Information for Billing Purposes

I authorize the release of any medical information necessary to process insurance claims, and request payment of benefits either to myself of to the part who accepts or participates.

Signature _____

Financial Policy

I understand that the provider's charge may exceed the insurance payments, and if greater than such payment, I will be responsible for that amount.

Signature_____

Consent to Release Prescription History

I agree to allow Lakeshore Internal Medicine and Pediatric Assoc to view my prescription history from external sources.

Signature _____