

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

Scott Parrott, PA-C

(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

APPOINTMENT REMINDERS: (Circle one)

TEXT AUTOMATED CALL BOTH

Language: _____

**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

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 or 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 _____