LAKESIDE
HEALTHCARE SPECIALISTS, PLLC

New Patient Information Sheet

Office Use Only:

Date Rec'd:_____ EPIC:_____

We are currently not taking any new Medicaid patients at this time, we apologize for any inconvenience

1) Insurance Primary/Secondary:_____

2) Previous Physician & Location:_____
What was the date of your last physical or wellness exam? (mm/dd/yyy):_____/_____/_____

3) Requested Physician: *(*Provider may only be accepting patients with their Residents)*

- ☐ Deskins*
- ☐ Gosling*
- ☐ S. Shastri
- ☐ Smalley*
- ☐ Sural*
- ☐ Any

4) Patient Name: Last_____ First_____ MI_____
Date of Birth:_____
Address:_____
_____
Telephone Number:___(_____)_____-_____

5) Medical Condition or reason for visit:

- ☐ New Primary Care- Establish Care for (list diagnosis and/or symptoms):_____
- ☐ Chronic Disease Management (Circle all that apply)
  - o Asthma
  - o Chronic Heart Failure
  - o Diabetes
  - o High Blood Pressure
  - o Other:_____
- ☐ New Diagnosis (list diagnosis): _____
- ☐ Pain Management
- ☐ Other (Please list):_____

6) Do you seek physician certification for medical marijuana? **YES** or **NO**
- If yes, our practice does not complete certification forms, and you will be required to seek this authorization elsewhere.

7) Current Medications: (list or supply copy) [Use back of page if you need additional space]

a. c.
b. d.

8) Employer: _____Address:_____ Phone:_____

TURN THIS COMPLETED FORM INTO THE FRONT DESK, WE WILL CONTACT YOU WHEN APPROVED/DENIED

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