Lakeview Clinic

Account #_____ **PATIENT INFORMATION** Date: _____

Patient Name: _____
Last First Middle

Address: _____
Street City State Zip

Sex: M or F Birthdate: ____/____/____ Social Security # ____/____/____

Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____

Name of Legal Guardian (if minor): _____
Last First Middle

Employed by _____ Work Phone (_____) _____ - _____

Email Address _____

Primary Pharmacy Name/City _____

Preferred method for Lakeview to communicate with you? Home Ph Cell Ph Mail Patient Portal

ADDITIONAL INFORMATION

Has any member of your family been treated at Lakeview Clinic? ___ Yes ___ No

If YES, Name and Relationship _____

How did you hear of Lakeview Clinic, Ltd.? _____

Name and address of Doctor who treated Patient last _____

Emergency Contact Person (not living in the same household) _____

Emergency Contact Phone (____) _____ - _____ Address _____

Please Present Insurance Cards To The Appointment Staff

Treatment Authorization: I hereby authorize Lakeview Clinic, Ltd., or their designee(s), to treat my or the patient's conditions as they deem appropriate.

Assignment of Benefits. I hereby assign the authorized benefits and direct that payment under any insurance policy or health benefits plan to be made directly to Lakeview Clinic, Ltd., for any services rendered to me or the Patient on behalf of Lakeview Clinic, Ltd.

HIPPA Privacy Act – I have received Lakeview Clinic, Ltd's, notice of HIPPA Privacy Act. I authorize Lakeview Clinic, Ltd., my health care providers, my insurer, health plan, care systems, ACO, claims administrator or pharmacy to share with each other my health information and health records for care coordination and quality improvement purposes. This includes sharing my health information and health records from treatment I have received at health care providers not related to Lakeview Clinic, Ltd.

I understand and agree that I am financially responsible to Lakeview Clinic, Ltd., for any and all charges not covered by insurance for myself, spouse and dependents.

FOR ALL THE ABOVE INFORMATION _____ Date: _____
Signature of Responsible Party/ Legal Guardian

Relationship to Patient: _____

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In accordance with Federal and State data collection requirements, we would like you to answer the following questions. Your answers will be kept confidential and will have no effect on the care you receive at Lakeview Clinic. If you prefer not to give this information, you can circle "Declined".

What country were you born in? _____ Declined

What race or ethnic group best describes you? Circle the groups that best describe you. Multiple selections are permitted.

American Indian or Alaska Native
Asian
Black or African American
Hispanic or Latino
Native Hawaiian/Pacific Islander
White
Unknown
Choose not to disclose/Declined

What is your primary language? (Circle one language)

Amharic	English	Karen	Russian	Tibetan
Arabic	French	Korean	Sign Language	Tigrinya
Bosnia	German	Laotian	Somali	Urdu
Burmese	Hearing Impaired	Mandarin	Spanish	Vietnamese
Cambodian	Hindi	Oromo	Swahili	Yoruba
Cantonese	Hmong	Polish	Tagalog	Unknown
Chinese	Japanese	Romanian	Thai	Declined

Other_____