



New Patient Form

Ross Hogan, MD | Sara Gaspard, NP | Michael Pinsky, MD | Eric Wendel, MD

Patient Name (Print): _____

Dob: ___/___/___ Age: ___ Male Female Marital Status: _____ SSN: _____

Home Phone #: _____ Cell Phone #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Preferred Language: _____ Ethnicity/Race: _____

Emergency Contact: _____ Relationship: _____

Contact Phone #: _____

Employer: _____ Work #: _____

Primary Care Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Power Of Attorney (If Applicable): _____ Relation To You: _____

Living Will: Yes* No (*If Yes, Please Provide A Copy For Our Records.)

I acknowledge that I have been provided with, or given the opportunity to review, all privacy policies, clinical documentation practices, and patient responsibilities through either physical, electronic, or online access. I confirm that I have read, understand, and agree to the terms outlined in these forms.

Patient Signature: _____ Date: _____

Parent / Guardian / P.O.A. Signature: _____ Date: _____

At Lakeshore Urology, our mission is to provide advanced, high-quality urologic care. We appreciate your trust and thank you for adhering to these policies.