East Lake Medical Center
2595 Tampa Road, Suite K
Palm Harbor, FL 34684
www.drtaunkinternist.com

PATIENT NAME: _____________ **AGE:** _____________ **SEX: M / F** **DATE OF VISIT:** ____________

HOW DID YOU HEAR ABOUT US? ____

REASON FOR TODAY'S VISIT: ____

____

____

CHECK IF YOU CURRENTLY HAVE ANY OF THE FOLLOWING:

ACID REFLUX DISEASE______
ANEMIA______
ANGINA______
ANXIETY______
ARTHRITIS______
ASTHMA______
ATRIAL FIBRILLATION______
BPH______
BACK PAIN______
BIPOLAR DISORDER______
CONGESTIVE HEART FAILURE_____
COLITIS, ULCERATIVE______
CROHN'S DISEASE______
COPD______

DEPRESSION______
DVT______
DIVERTICULOSIS______
DIABETES MELLITUS______
FIBROMYALGIA______
GOUT______
HYPERTENSION______
HEPATITIS______
HYPERCHOLESTEROLEMIA______
HERNIATED DISK______
IRRITABLE BOWEL SYNDROME_____
KIDNEY STONE______
MYOCARDIAL INFARCTION_____
MIGRAINE HEADACHE______

OBESITY______
PERIPHERAL NEUROPATHY______
PARKINSON'S DISEASE______
PULMONARY EMBOLISM______
SCIATICA______
SYSTEMIC LUPUS______
STROKE______
SEIZURE______
HYPOTHYROIDISM______
HYPERTHYROIDISM______
TIA______
THYROID NODULE______
URINARY INCONTINENCE______

PAST SURGICAL HISTORY:____

____

____

ALLERGIES TO MEDICATIONS:____

____

MEDICATION LIST: ____

____

____

FAMILY HISTORY: (CHECK ONE)	**BREAST CANCER**	**YES_____ NO_____**
	COLON CANCER	**YES_____ NO_____**
	HIGH BLOOD PRESSURE	**YES_____ NO_____**
	DIABETES	**YES_____ NO_____**
	HEART ATTACK	**YES_____ NO_____**

PERSONAL HISTORY: (CHECK ONE)	**SMOKER**	**YES_____ NO_____**
	IF SO, HOW MANY PACKS PER DAY _______________	
	ALCHOL (HEAVY DRINKING)	**YES_____ NO_____**
	ALCHOL (SOCIALY)	**YES_____ NO_____**
	MARRIED	**YES_____ NO_____**

JOB DESCRIPTION: ____

PREVENTATIVE HISTORY:	**COLONOSCOPY**	**DATE: ______ RESULTS: ______**
	MAMMOGRAM (FEMALES)	**DATE: ______ RESULTS: ______**
	PAP SMEAR (FEMALES)	**DATE: ______ RESULTS: ______**
	PSA (MALES)	**DATE: ______ RESULTS: ______**

REVIEWED BY VIJAY L. TAUNK, M.D.____

PATIENT REGISTRATION SHEET

NAME ________________________________ SS# ______________________________________
STREET ADDRESS _____________________ DOB ______ MARITAL STATUS –S M W SEP D
CITY____________________________________STATE __________ ZIP ______________________
TELEPHONE: (CELL)______________(HOME)_____________(OFFICE) ________________
REFERRED BY____
SPOUSE'S NAME____
SPOUSE'S EMPLOYER & ADDRESS____
EMERGENCY CONTACT_______________________TEL#______________REL____________

PATIENT EMPLOYER INFORMATION

EMPLOYER NAME_______________________TEL#____________________________________
EMPLOYER STREET ADDRESS_______________________CITY/STATE _________ZIP______
PATIENT OCCUPATION____

INSURED PERSON (IF NOT PATIENT)

NAME___________________________________TEL#_____________________________________
STREET ADDRESS__________________________________CITY/STATE____________ZIP______
RELATIONSHIP TO
PATIENT____

INSURANCE

MEDICAID# (IF APPLICABLE)________________MEDICARE# (IF APPLICABLE) ____________
PRIMARY INSURANCE COMPANY NAME____
ID#_________________________________GROUP #______________________TEL#___________
SECONDARY INSURANCE COMPANY NAME____
ID#_________________________________GROUP #______________________TEL#___________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFIT

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

DATE________________________________ SIGNATURE_________________________________

I HEREBY AUTHORIZE DR. VIJAY TAUNK TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED BY HER OR BY HER ORDER. I REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO DR. VIJAY TAUNK (OR TO THE PARTY WHO ACCEPTS ASSIGNMENT).

I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT.

I PERMIT COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. THIS AUTHORIZATION MAY BE REVOKED BY EITHER ME OR MY INSURANCE COMPANY AT ANY TIME IN WRITING.

DATE___________________________ SIGNATURE_____________________________________
(PATIENT, PARENT, OR GUARDIAN)

Eastlake Medical Center
Notice of Privacy Practice

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At Eastlake Medical Center law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information.

We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law. If this practice is sold, your information will become property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail for file for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for these copies. You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independent Ave., S.W., Room 509F, Washington D.C., 20201.

You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Erika, at (727)789-6551.

This notices is in effect as of April 14, 2003.

Notice of Privacy Practices

Acknowledgement:

I have read the copy of the EASTLAKE MEDICAL CENTER Notice of Privacy Practices.

Date: ______________

Print Name: ______________________________

Signature: ______________________________

If signing as a parent or guardian, please note the name of the patient:

Print Name: ______________________________

I authorize release of my medical information and records to the following:

Name: ______________________________ Relationship: ________________

Name: ______________________________ Relationship ________________

Name: ______________________________ Relationship ________________

Name: ______________________________ Relationship ________________

Patients Signature: ____________________________ Date: ________________

(OPTIONAL)

LIVING WILL

DECLARATION

I, ______________________________, being of sound mind, willfully and voluntarily make this declaration to be followed if I become incompetent. This declaration reflects my firm and settles commitment to refuse life-sustaining treatment under the circumstances indicated below.

I direct my attending physician to withhold or withdraw life-sustaining that serves only to prolong the process of my dying, if I should be in a terminal condition or in a state of permanent unconsciousness.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment.

In addition, if I am in the condition described above, I feel especially strongly about the following forms of treatment:

I ( )do ( )do not want cardiac resuscitation

I ( )do ( )do not want mechanical respiration

I ( )do ( )do not want tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water).

____

I ( )do ( )do not want to designate another person as my surrogate to make medical treatment decisions for me if I should be incompetent and in a terminal condition or in a state of permanent unconsciousness.

Name and address of surrogate (if applicable) :

____

____

Name and address of substitute surrogate (if surrogate designated above is unable to serve):

____

____

I made this declaration on the __________day of ____________________, 20_____.

Declarant's signature: ____

Declarant's address: ____

Witness' signature: ____

Witness' address: ____