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)