T. ANN TONNU, M.D., LLC

Phone: 301-721-1614

9057 Shady Grove Court
Gaithersburg, MD 20877

NAME:_____ SEX: Male/Female

DATE OF BIRTH:_____ CELL PHONE: _____

HOME PHONE:_____ WORK PHONE:_____

EMAIL ADDRESS: _____

MARITAL STATUS:_____ SSN:_____

ADDRESS:_____

PHARMACY NAME AND ADDRESS: _____

OCCUPATION:_____ EMPLOYER:_____

EMPLOYER ADDRESS:_____

NAME OF SPOUSE/PARENT: _____

REFERRED BY:_____PRIMARY PHYSICIAN_____

NAME OF INSURED PERSON:_____ SSN OF INSURED:_____

NAME OF INSURANCE COMPANY:_____

INSURANCE ID NO.:_____ PLAN NO.:_____

IN CASE OF EMERGENCY, CONTACT NAME/PHONE:_____

DESIGNATED PERSON'S NAME AND RELATION FOR OBTAINING MEDICAL INFORMATION: _____

AUTHORIZED METHOD TO LEAVE MESSAGE: CELL ____ WORK_____ HOME_____
INCLUDING PRIVATE HEALTH INFORMATION (Please check all apply)

Authorization to Release Information

I hereby authorize T. Ann Tonnu, M.D., LLC to apply for benefits on my behalf for covered services rendered. I request payment from my insurance companies be made directly to T. Ann Tonnu, M.D., LLC.
I certify that the information above regarding the insurance coverage is correct and authorize the release of any necessary information in order to determine any benefits to which I may be entitled. I understand that I will be responsible for my bill until it is paid in full. I understand that I will pay my bill within 30 days or will be liable for any collection actions.
I certify that I have been presented with a Privacy Notice explaining my rights regarding my individually identifiable health information (IIHI). I consent to the use and/or disclosure of my IIHI for the purposes of treatment, payment or other health care operations (TPO). Other uses of my IIHI will require an authorization from me for the specific intention of disclosure.

SIGNATURE_____ DATE_____

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PATIENT INFORMATION

Name: _____

Reason for today's visit: Check all that applied

__Colon Screening __Abdominal Pain __Rectal Bleeding __Acid Reflux

__Abnormal Liver Test __Hepatitis B/C __Diarrhea __Change Bowel Habit

PAST MEDICAL HISTORY (Circle Yes/No)

Hypertension	Yes/No	Heart Disease	Yes/No	Hypercholesterolemia	Yes/No
Diabetes	Yes/No	Gout	Yes/No	Hepatitis	Yes/No
Asthma	Yes/No	Arthritis	Yes/No	Sleep Apnea	Yes/No
Seizures	Yes/No	Irregular Heart Rate Y/N		Bleeding problem	Yes/No

Cancer Yes/No If Yes, please list type: _____

Any hospital stay, including surgeries, starting with most recent:

DATE (mm/dd/yyyy)	REASON	HOSPITAL

Have you ever received any blood transfusion? ___No ___Yes When:_____(mm/dd/yy)

LIST PRESCRIPTION-INCLUDING BIRTH CONTROL

Medication	Dosage

MEDICAL HISTORY

ALLERGIES-
Of the following, are you allergic to:
Which antibiotics?_____
Which foods? _____
Latex? Yes/No
Sedatives? Yes/No
Other _____

___No known allergies

HABITS:
Do you use tobacco? Yes/No
If "Yes", how much? _____
Do you drink alcohol? Yes/No
If Yes, How many drinks per day? _____

Do you use narcotics or addictive drug? Yes/No
If yes, what's type?_____
And how often? _____

FAMILY HISTORY
Check (X) if there is anyone in your immediate family with a history of:

Circle all that apply

__ Asthma	Father/Mother/Brother/Sister/Cousin/Grand Parent
__ Birth Defect	Father/Mother/Brother/Sister/Cousin/Grand Parent
__ Cancer	Father/Mother/Brother/Sister/Cousin/Grand Parent
What Type of Cancer _____	
__ Cystic Filbrosis	Father/Mother/Brother/Sister/Cousin/Grand Parent
___Depression	Father/Mother/Brother/Sister/Cousin/Grand Parent
___Diabetes	Father/Mother/Brother/Sister/Cousin/Grand Parent
___Heart attack	Father/Mother/Brother/Sister/Cousin/Grand Parent
___Heart disease	Father/Mother/Brother/Sister/Cousin/Grand Parent
___High blood pressure	Father/Mother/Brother/Sister/Cousin/Grand Parent
___High cholesterol	Father/Mother/Brother/Sister/Cousin/Grand Parent
___Mental retardation	Father/Mother/Brother/Sister/Cousin/Grand Parent
___Nervous breakdown	Father/Mother/Brother/Sister/Cousin/Grand Parent
___Seizures	Father/Mother/Brother/Sister/Cousin/Grand Parent
___Stroke	Father/Mother/Brother/Sister/Cousin/Grand Parent
___Thyroid problem	Father/Mother/Brother/Sister/Cousin/Grand Parent

Patient's Name:_____Signed_____Date ___/___/____
mm/dd/yyyy

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