CHARM CITY HEALTHCARE, LLC
PANKAJ KHETERPAL, MD
223 EASTERN BLVD
Essex, MD 21221

PHONE (410) 687 8818
FAX (410) 682 3989

PATIENT PROFILE

Full Name: _____ **S M W D**

Address: _____

City: _____ State: _____ Zip: _____

Phone: Cell :_(___)_____ Home:_(___)_____

Sex: Male: ____ Female: ____ DOB: _____ Age: _____

Social Security #:_____

Email: _____

Referred by:

Next of Kin:

Name: _____

Address: _____

Phone:_____ Relationship:_____

Insurance Information

Insurance: _____

Policy #: _____

Policy Holder's Name _____

Relationship to Policy Holder: Self___ Spouse___ Son___ Daughter___

Self Pay: _____

I authorize CHARM CITY HEALTHCARE, LLC to apply for benefits rendered. I request payment from my insurance company to be made directly to them. I certify that the information I have reported concerning my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of authorization to be used in place of the original. The authorization may be revoked by me at anytime in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided when a statement is rendered.

_____ _____

Signature of Subscriber or Beneficiary Date

CHARM CITY HEALTHCARE, LLC
PANKAJ KHETERPAL, MD
223 EASTERN BLVD
BALTIMORE, MD 21221

PHONE (410) 687 8818
FAX (410) 682 3989

PATIENT NAME: _____ **DOB:** _____

ALLERGIES: _____

_____

_____

Medication/Dose	Refill/Date

CHARM CITY HEALTH CARE, LLC 223 EASTERN BLVD PHONE: 410-687-8818

PANKAJ KHETERPAL, MD ESSEX, MD 21221 FAX: 410-682-3989

AUTHORIZATION FOR MEDICAL RECORDS RELEASE

PATIENT INFORMATION: **REQUEST RELEASE INFORMATION:**

NAME: _____ **NAME:** _____

ADDRESS: _____ **ADDRESS:** _____

_____

CITY, STATE, ZIP: _____ **CITY, STATE, ZIP:** _____

_____

DOB: _____

SSN: _____

I HEREBY AUTHORIZE YOU TO RELEASE TO **CHARM CITY HEALTH CARE, LLC** A COPY OF MY MEDICAL RECORDS TO BE USED FOR CONTINUING MEDICAL CARE. I RESERVE THE RIGHT TO REVOKE THE AUTHORIZATION IN WRITING AT ANY TIME. I FURTHER AGREE AND UNDERSTAND THAT THIS **PROTECTED HEALTH INFORMATION** MAY BE RE-DISCLOSED BY THE RECIPIENT AND THUS, NO LONGER PROTECTED UNDER PRIVACY RULES.

_____ _____

PATIENT OR GUARANTOR SIGNATURE TODAY'S DATE

PLEASE INCLUDE FOLLOWING ITEMS:

_____**ADMISSION NOTES** _____**PROGRESS NOTES**

_____**DISCHARGE SUMMARY** _____**PATHOLOGY REPORTS**

_____**OPERATIVE REPORTS** _____**CONSULTATIONS**

_____**LABORATORY** _____**EKG'S**

_____**X-RAY REPORTS** _____**STRESS TEST**

REMARKS: _____

_____

THIS AUTHORIZATION WILL EXPIRE ON _____/_____/_____

CHARM CITY HEALTHCARE, LLC
PANKAJ KHETERPAL, MD
223 EASTERN BLVD
ESSEX, MD 21221

PHONE (410) 687 8818
FAX (410) 682 3689

NOTICE OF PRIVACY PRACTICES

OBJECTIVES:

The management of all patient information in the strictness of confidence.

CONFIDENTIALITY ISSUES:

- Medical Charts
- Insurance claims and all billing issues
- Telephone calls (inclusive of appointment conformation, lab results, and/or any other necessary information)
- Prescription instruction, changes in medications, and/or notifying pharmacies of new medications
- Release of records for specialists, and/or other personal requests
- Requisitions for lab work, x-rays, other test, and referrals to other specialists
- Disclosure permitted to physicians, family members, and/or others of your healthcare information.

PERMISSION:

YES _____ **NO**_____

Signature: _____ **Date:**_____

Print Name: _____

Please be advised that your signature is valid for six (6) years unless written notification has been submitted to *DR. PANKAJ KHETERPAL*.

CHARM CITY HEALTHCARE LLC
223, EASTERN BLVD
ESSEX MD 21221

New Patient Health Questionnaire

Name:_____ **Date:** _____

DOB: _____ **Age:** _____

PLEASE NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

What medical concerns bring you to our office? _____

Marital Status: (circle) S M D W **Occupation:** _____

Have you ever smoked? No Yes
Do you still smoke now? No Yes

MEDICAL INFORMATION

Allergies: Are you allergic to any drugs? (circle) No Yes Please list:
Medications (list all medications you are taking regularly. Include over the counter, herbal or natural remedies.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medical Illnesses or Conditions:_____

Have you ever had or been diagnosed to have? *(check box by all that apply)*

Cataracts		Heart Disease		Ulcers		Anemia		Depression	
Glaucoma		Heart Murmur		Digestive Disorder		Bleeding Disorders		Cancer (type)	
Asthma		High Blood Pressure		Hemorrhoids		Bone or Joint Disease		High Cholesterol	
Allergies		Pneumonia		Kidney Disease		German Measles		Prostate Enlargement	
Stroke		TB/Lung Disease		Kidney Stone(s)		Rheumatic Fever			
Seizures/Epilepsy		Pleurisy		Diabetes or Pre-Diabetes		Chicken Pox			
Heart Attack or Angina		Jaundice or Liver Disease		Thyroid Disease		Syphilis			

Operations:
(please list any surgery and approx. year)

Hospitalizations in last 12 months
(other than operations)

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ESSEX MD 21221

#	Year	Surgery		Year	Reason
1					
2					
3					
4					
5					

Family Medical History:

Relationship	Age	Medical Issues	If deceased, age at death and cause, if known
Father			
Mother			
Brother or Sister			

Has any BLOOD relative ever had? *(check if Yes and indicate relationship)*

Alzheimer's		Heart Attack before age 55		Mental Disorder	
Diabetes		Bleeding Disease		Cancer	
High Blood Pressure		Stroke			
Heart Disease		Alcoholism			

Immunizations (check if Yes and indicate year of last injection)

Influenza		Pneumonia		MMR	
Tetanus		Shingles		Other	

Females Only: Are you pregnant, planning a pregnancy or nursing a child? (circle) No Yes

Date of last menstrual period? _____

Systems Review: Please indicate those items that have been a recurrent or a recent significant change.

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Yes	No	Constitutional Symptoms
___	___	Good health lately
___	___	Recent significant weight change
___	___	Unusual fatigue or weakness
___	___	Frequent headaches

Yes	No	Eyes
___	___	Change in vision
___	___	Blurred or double vision
___	___	Eye disease or injury
___	___	Wear glasses/contact lenses?

Yes	No	Ears/Nose/Mouth/Throat/Neck
___	___	Do you wear hearing aids?
___	___	Hearing loss or ringing in ears?
___	___	Earaches or drainage?
___	___	Chronic sinus problems or runny nose
___	___	Nose bleeds
___	___	Mouth sores
___	___	Bleeding gums
___	___	Sore throat/hoarseness or voice change
___	___	Lumps or swollen glands in neck
___	___	Difficulty swallowing
___	___	Neck pain or stiffness

Yes	No	Cardiovascular
___	___	Heart trouble
___	___	Chest pain or angina
___	___	Palpitations
___	___	Shortness of breath with walking or lying flat
___	___	Swelling feet, ankles or hands
___	___	Waking at night with shortness of breath

Yes	No	Respiratory
___	___	Chronic or frequent cough
___	___	Coughing or spitting up blood
___	___	Shortness of breath
___	___	Asthma or COPD

Yes	No	Gastrointestinal
___	___	Recent loss of appetite
___	___	Recent change in bowel movements
___	___	Painful bowel movements or constipation
___	___	Frequent stools
___	___	Rectal bleeding or blood in stool
___	___	Stomach/abdominal pains or heartburn
___	___	Black or tarry stools

Yes	No	Psychiatric
___	___	Memory loss

Yes	No	Genitourinary
___	___	Frequent urination
___	___	Burning or pain on urination
___	___	Blood in urine
___	___	Change in force or strain when urinating
___	___	Incontinence or dribbling of urine
___	___	Men: Testicular pain
___	___	Women: Painful periods
___	___	Irregular periods
___	___	Recurrent vaginal discharge

Number of pregnancies (including miscarriages): ___
___ # Deliveries ___ #Miscarriages
Method of birth control (if applicable): _____
Date of last menstrual period: _____
Date of last pap smear: _____
Date of last mammogram: _____

Yes	No	Musculoskeletal
___	___	Joint pain(s)
___	___	Joint stiffness/swelling
___	___	Weakness of muscles
___	___	Muscle pain
___	___	Back pain
___	___	Difficulty in walking

Yes	No	Integumentary (Skin/Breast)
___	___	Rashes or itching
___	___	Change in skin color or moles
___	___	Change in hair or nails
___	___	Varicose veins

Yes	No	Neurological
___	___	Frequent, recurring or increasing headaches
___	___	Light-headedness or dizziness
___	___	Convulsions, seizures or spasms
___	___	Numbness or tingling sensations
___	___	Tremors
___	___	Mini Stroke (TIA)

___	___	Insomnia
___	___	Depression

Yes	No	**Endocrine**
___	___	Heat or cold intolerance
___	___	Excessive skin dryness
___	___	Excessive thirst or urination

Yes	No	**Hematology**
___	___	Slow to heal after cuts or wounds Bleeding or bruising tendency.
___	___	Anemia
___	___	Clotting Disorder

Comments: _____

Patient signature: _____ **Reviewed By:** _____

Date: _____ **Date:** _____

Physician Signature: _____ **Date:** _____