Rajeev Batra, MD
11120 New Hampshire Ave., #300
Silver Spring, MD 20904
(301) 593-9612
Fax: (301) 593-6290
52-2057492

PATIENT INFORMATION

Patient Name:_____ **D.O.B.:_____**
Phone #:_____ **Work #:_____**
Pharmacy #: _____

PROBLEMS

DRUG ALLERGIES: _____ _____ _____ _____

MEDICATIONS

NAME	DATE UPDATED	DATE UPDATED	DATE UPDATED	DATE UPDATED

PREVENTIVE CARE / DIAGNOSTIC TESTS

NAME	DATE UPDTAED	DATE UPDATED	DATE UPDATED	DATE UPDATED
PAP SMEAR				
MAMMOGRAM				
COLONSCOPY				
E K G				
ECHO				
BONE DENSITY				
STRESS TEST				
HOLTER				
SPIROMETRY				
PNEUMOVAX/FLU				
PHYSICAL EXAM				
ABI				
CAROTID DUPLEX				
NEURAL SCAN				
EYE EXAM				

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LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH

ADDRESS	APT #	SOCIAL SECURITY NUMBER

CITY	STATE	ZIP CODE	SEX

HOME PHONE	WORK PHONE	OTHER PHONE

E-MAIL ADDRESS

EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP

ADDRESS

CITY	STATE	ZIP CODE

HOME PHONE	WORK PHONE	CELL PHONE

INSURANCE INFORMATION

NAME OF INSURANCE

POLICY HOLDER'S INFORMATION (IF DIFFERENT FROM PATIENT)

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH

ADDRESS	SOCIAL SECURITY NUMBER

CITY	STATE ZIP CODE	RELATIONSHIP TO PATIENT

HOME PHONE	WORK PHONE	OTHER PHONE

PATIENT AUTHORIZATION

I_____, hereby authorize Rajeev Batra, MD to apply for benefits on my behalf for covered services rendered. I request payment from BCBS National Capital Area, Blue Shield of Maryland, Blue Shield of Virginia, Medicare, and / or _____(name of other ins. Company.) Insurance Company, be made directly to the above-named provider (or in case of Medicare Part B benefits, to myself or the party who accepts assignment.) I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. The authorization may be revoked by either the above named carrier or me at any time in writing.
I request that payment of the authorized Medigap benefits be made to me or on my behalf to the above named provider for any services furnished me by the physical/supplier. I authorize any holder of medical information about me to release to_____ any information need to determine these benefits payable for related services.

* Please note that in the unfortunate event your account is transferred to collections, you the patient are responsible for any fees associated with the collection effort.*

_____ _____
Date Signature of subscriber or Beneficiary

RAJEEV BATRA, MD
DIPLOMATE OF AMERICAN BOARD OF INTERNAL MEDICINE
GENERAL AND FAMILY PRACTICE
11120 NEW HAMPSHIRE AVE, SUITE 300
SILVER SPRING, MD 20904
(301) 593-9612
TAX ID 52 2057492

HISTORY AND PHYSICAL

NAME:_____ **DATE:**_____

REASON FOR VISIT:

_____

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY

HEADACHE	**SWOLLEN ANKLES**	**STROKE**
HEART ATTACK	**HEART DISEASE**	**CHEST PAIN**
THYROID PROBLEMS	**STOMACH ISSUES/ULCERS**	**PERIPHERAL VASCULAR DISEASE**
EMPHYSEMA	**MITRAL VALVE PROLAPSE**	**HEART MURMUR**
GLAUCOMA	**BOWEL IRREGULARITY**	**ALLERGIES/HAY FEVER**
RESPIRATORY ISSUES	**PROSTATE DISEASE**	**AIDS OR HIV INFECTION**
HEART PALPATATIONS	**ASTHMA**	**SEXUAL/MENSTRUAL DYSFUNCTION**
INCONTINENCE	**NERVOUSNESS**	**SHORTNESS OF BREATH**
OSTEOPOROSIS	**GOUT**	**DIABETES**
STD	**EPILEPSY/CONVULSIONS**	**ANGINA**
DEPRESSION	**CARDIAC PACEMAKER**	**CANCER**
RECENT WEIGHT LOSS	**DIZZINESS/FAINTING**	**ANEMIA**
BRONCHITIS	**JOINT REPLACEMNT/IMPLANT**	**HIGH BLOOD PRESSURE**
KIDNEY DISEASE	**FREQUENTLY TIRED**	**TUBERCULOSIS**
LIVER DISEASE	**PNEUMONIA**	**HEPATITIS/JAUNDICE**
ARTHRITIS	**OTHER**_____	**OTHER**_____

OTHER_____

_____

_____

_____

HABITS_____
SLEEP: DIFFICULTY SLEEPING_____
CONTINUITY DISTURBANCES____
SNORING_____
DAYTIME DROWSINESS_____
OTHER:_____
WOMEN ONLY_____
PREGNANT? YES NO **PLANNING PREGNANCY? YES NO**
LAST PAP SMEAR_____ **LAST MAMOGRAM**_____

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TRANSFER OF MEDICAL RECORDS REQUEST

I _____ authorize the release of Medical Records to Dr. Batra.

Patient Information:

Date of Birth: _____
Social Security Number: _____

From Address:

To Address:

Rajeev Batra, MD
11120 New Hampshire Ave., #309
Silver Spring, MD 20904
Office: (301) 593 9612
Fax: (301) 593 6290

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Rajeev Batra, MD
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GENERAL AND FAMILY PRACTICE
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I understand that, under the health insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand you *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

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Office Policy:

- All patients are responsible to know their own insurance benefits and policy.
- They are also responsible to know the amount of their own deductible.
- . If you have a balance in the office you will receive a bill each month for three months.
- It is your own responsibility to notify the office with address and phone number changes. If you do not receive a bill due to wrong address it is your own responsibility.
- After the third month your account will automatically be sent to collections.
- . Please be informed a collection charge of forty percent will be added for delinquent accounts.
- It is our office policy to inform all results to patient.
- If you have lab tests or X-Rays please contact our office for results if you do not hear from us within 2 weeks.
- We reserve the right to charge a fee of $35 for missed appointments if it is not canceled at least 48 hours in advance..

Sign_____ Date_____