3320 Executive Drive
Building 3, Suite 222
Raleigh, NC 27609

Metro Internal Medicine P.A.
Kenneth A. Holt, M.D.

Tele: 919-877-1100
Fax: 919-877-8118
www.mimnc.com

Personal Contact and Insurance Information

Please fill out this form as completely as possible to help us update your medical history. Thank You.

Demographic Information

Patient Name: _____ Date of Birth _____

Home Address: _____
Street Apartment

_____ _____ _____
City State Zip

Telephone - Home: _____ Work: _____ Cell: _____

Patient's Email: _____

Social Security Number: _____ Driver License: _____
State Number

Preferred method of contact: ☐ Email Phone: ☐ Home ☐ Cell ☐ Work

Is it permissible to leave personal information on messages? ☐ Yes ☐ No

Primary Care Physician: _____ Referred by: _____

Marital Status: ☐ Married ☐ Single ☐ Separated/Divorced ☐ Widowed Gender: _____

Employment Status: ☐ Employed ☐ Retired ☐ Student ☐ Other _____

Race: Please check all boxes applicable to you.

Caucasian ☐ Hispanic/Spanish/Latin ☐ Other ☐

Asian or Asian Indian ☐ American Indian or Alaska Native ☐

Black or African-American ☐ Native Hawaiian or Other Pacific Islander ☐

Are you Jewish/of Jewish descent? No ☐ Yes ☐

Preferred Language: _____

Primary Insurance Information

Name of Primary Insurance Company: _____

Insured's Name: _____ DOB: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Insurance Company's Address: _____
Street

_____ _____ _____
City State Zip

Subscriber Number: _____ **Group Number:** _____

Secondary Insurance Information

Name of Secondary Insurance Company: _____

Insured's Name: _____ DOB: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Insurance Company's Address: _____
Street

_____ _____ _____
City State Zip

Subscriber Number: _____ **Group Number:** _____

Spouse/Partner/Guarantor/Responsible Party

Name: _____ ☐ Guarantor ☐ Spouse ☐ Other_____

Relationship to you: _____ Gender: _____

Address: _____
Street Apartment

_____ _____ _____
City State Zip

Telephone (home): _____ Work: _____

Emergency Contact

Same as: ☐ Spouse/Partner

Name: _____

Relationship to you: _____ Gender: _____

Telephone - Home: _____ Work: _____ Cell: _____

Advanced Directive

Do you have an Advanced Directive, Living Will or Healthcare Power of Attorney? ☐ Yes ☐ No

If you answered "yes", please consider providing us with a copy for your chart.

If you do not have an advanced directive, living will or healthcare power of attorney and want one, a very user friendly one is available from www.caringinfo.org . Simply click on the "Download Your State Specific Advance Directive" link and find your home state.
The North Carolina form is here: http://www.caringinfo.org/files/public/ad/NorthCarolina.pdf.

Continue to the next page…

Special Notices

Release of Information to Insurance Companies and Health Care Providers

I authorize the release of any medical or other information necessary to process claims on my behalf or for continuation of my health care.

No-Show/Cancellation Fees

In order to insure timely and efficient care for all of our patients there will be a $25 fee for missed appointments or appointments cancelled within less than 24 hours. Exceptions to this policy may be made in the case of an emergency or at the physician's discretion.

Office Policy on Managed Care Insure

Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know at EACH time of services exactly what those guidelines are.
It is responsibility of the patient to inform us of any special requirements with your insurance that we subsequently order services for, such as lab work, consultations, and/or hospitalization. Payment for ALL charges are your responsibility.

I have read and understood the office policy stated above for Metro Internal Medicine and agree to accept responsibility for all balances incurred as described.

HIPPA CONSENT

(Full HIPPA policy available upon request)
The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. We will not release information to any other entity without your written consent.

May we disclose medical information to anyone other than yourself? ☐ Yes ☐ No

If yes, please list: _____ _____

_____ _____

Patient Name (printed): _____ **Date:** _____

Patient Signature: _____

Authority to sign, if not patient: _____

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Personal Medical History

NAME: _____ **DOB:** _____

Please fill out this form as completely as possible to help us update your medical history. This form is *confidential;* however, if you prefer you can discuss these matters (or other personal matters) directly with the nurse or Dr. Holt.

Chronic Medical Problems

Surgical and Hospitalization History

Reason for hospital visit or surgery	Facility	Date

Allergies

Allergen (what causes the reaction)	Type of reaction

Continue to the next page…

Medications, Supplements and OTC drugs	
Medication, dose, frequency, route	**Date Started**

If you need more space please use the back of this page.

Immunizations		
Immunization	**Provider**	**Date**
Flu		
Pneumonia		
Shingles		
Tetanus		
Hepatitis		
Meningitis		

Other Physicians and Care Providers		
Name & Specialty/Provider Type	**Type of care**	**Date discontinued**

Preferred Pharmacy (local and mail order, if applicable)	
Name	**Phone number**
Local:	
Mail Order:	

Continue to the next page…

Family Medical History

	Deceased	Diabetes	High Blood Pressure	Heart Disease	Stroke	Mental Illness	Cancer (type)	Kidney disease	Genetic disorder	Liver disease
Father										
Mother										
Brother(s)										
Sister(s)										
Son(s)										
Daughter(s)										
Pat. Grandfather										
Pat. Grandmother										
Mat. Grandfather										
Mat. Grandmother										

Other: _____

Personal Social History

Tobacco: ☐ **Current** **Type (including vapes & e-cigs):** _____ **Freq:** _____
☐ **Never** ☐ **Prior use** **Quit date:** _____

Recreational drug use: ☐ **Never** ☐ **Occasional** ☐ **Daily** ☐ **Prior use**
Quit date: _____ **Type of Drug:** _____

Alcohol: ☐ **Never** ☐ **Occasional** ☐ **Daily** **History (please describe):**

Exercise type/frequency:	**Birthplace:**
Sexually active: ☐ Yes ☐ No	**Have you travelled outside the USA within the past 6 months? (please list)** ☐ No ☐ Yes_____
Occupation:	**Hobbies:**

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

*required, please leave other sections blank until records are needed

*Patient's Name: _____ *Birthdate: _____

*Street Address: _____ *Social Security #: _____

*City, State, Zip: _____ *Phone # (home): _____

(work): _____

*Maiden/Other Names: _____

I authorize Metro Internal Medicine to release and/or receive information in my patient records as directed below:

1. Name and address of person or organization with whom medical information is to be exchanged:
   Name: _____ Phone: _____

   Address (City, State, Zip): _____
2. Purpose of disclosure: _____
3. Dates of service: From _____ To _____
4. Specific provider's records to be released: _____
5. Revocation/Expiration. This authorization is valid for 2 years unless otherwise noted but can be revoked in writing, which must be signed and dated, at any time, unless the provider marked above has already acted upon your request.
6. Fees. There may be a fee associated with the processing of this request. Please check with staff for estimated costs. The providers marked above frequently contract with third party vendors for confidential record copy services, so the bill for records copy may be generated by a third party vendor.
7. Method of release: ☐ Mailed ☐ Faxed ☐ emailed ☐ Picked up (☐Paper ☐ CD)
   If records are to be emailed I acknowledge that email is inherently unsecured. And, while the providers marked above will make every effort to insure security on their end they have no control over the security of my email.
8. Important Notice: THE CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS ARE PROTECTED BY NORTH CAROLINA AND FEDERAL LAWS AND REGULATIONS. THE CONFIDENTIALITY LAWS AND REGULATIONS PROHIBIT THE DISCLOSURE OF THESE RECORDS *UNLESS* ONE OF THE FOLLOWING CONDITIONS IS MET:
   a. THE PATIENT CONSENTS IN WRITING;
   b. THE DISCLOSURE IS ALLOWED BY A COURT ORDER;
   c. THE DISCLOSURE IS MADE TO MEDICAL PERSONNEL IN A MEDICAL EMERGENCY OR TO QUALIFIED PERSONNEL FOR RESEARCH, AUDIT OR PROGRAM EVALUATION.

   VIOLATION OF THESE LAWS AND REGULATIONS IS A CRIME. SUSPECTED VIOLATION MAY BE REPORTED TO APPROPRIATE AUTHORITIES IN ACCORDANCE WITH THE LAWS AND REGULATIONS. FEDERAL LAWS AND REGULATIONS DO NOT PROTECT ANY INFORMATION ABOUT SUSPECTED CHILD ABUSE OR NEGLECT FROM BEING REPORTED UNDER STATE LAW TO STATE OR APPROPRIATE LOCAL AUTHORITIES.

My authorization to disclose the above information is voluntary, and the providers marked above will not condition the provision of treatment on this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected by the laws and regulations applicable to the providers marked above.

_____ _____

*Signature *Date

_____

*Authority to sign, if not patient

Copy to Patient