



**Metro Internal Medicine P.A.  
Facsimile Transmittal Sheet  
Dr Kenneth A. Holt, MD**

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**Demographic Information:**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

Street

Apartment Number

City

State

Zip Code

Telephone (Home): ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Street

City

State

Zip Code

Social Security Number: \_\_\_\_\_ Driver License: \_\_\_\_\_

State

Number

**Name of Primary Insurance Company:** \_\_\_\_\_

Name of Responsible Party If Different Than Patient: \_\_\_\_\_

Address of Insurance Company: \_\_\_\_\_

Street

City

State

Zip Code

**Subscriber Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_

Name of Responsible Party If Different Than Patient: \_\_\_\_\_

Address of Insurance Company: \_\_\_\_\_

Street

City

State

Zip Code

**Subscriber Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referred By: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Telephone (Work): ( ) \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Street

City

State

Zip Code

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be fully responsible for all lawful debts incurred by myself for services received from Metro Internal Medicine whether covered by insurance or not.