Metropolitan Medical Consulting Services, LLC
Kimberly L. Bolling M.D.
4000 Mitchellville Road Suite B424
Bowie, MD 20716
Phone: 301-352-0090
Fax: 301-390-6029

LAST NAME	*FIRST NAME*	*Date of Birth*

SEX **(CIRCLE ONE)**	***STATUS*** **(CIRCLE ONE)**	**STUDENT** **(CIRCLE ONE)**
Female Male	Single Married Divorced Widowed Partner	No Full Time Part Time

STREET ADDRESS	**CELL #:_____**
_____	**HOME #:_____**
	WORK #:_____

RACE/ETHNICITY **(CIRCLE ONE)**

White Black/African American Asian
Hawaiian Other Pacific Islander Native
American Indian/Alaska Other Race

Hispanic Latino Not Hispanic or Latino

Preferred Pharmacy

Name:_____
Phone#:_____
Address:_____
_____

How did you hear about us? **(CIRCLE ONE)**

Online Friend Family Other Physician
Insurance Other:_____

EMAIL

_____

EMERGENCY CONTACT

Name:_____ Cell#_____ Relationship:_____

INSURANCE

Insurance Name:_____ Insurance ID:_____
Group #:_____ Member Relationship(CIRCLE ONE): Self Spouse Child Other

(If the guarantor information is left blank, the patient will be assumed the responsible/billed party.)

Guarantor's Name:_____ Guarantor's DOB :_____
Guarantor's Address:_____

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to MMCG, PC, or any of its affiliates or agents, lenders, or any third party servicer acting for MMCG, PC or any of its affiliates. I also authorize to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

_____ _____

SIGNATURE **DATE**

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

If any MMCG Health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test.

I understand that this consent will remain in effect as long as my dependent or I receive care from MMCG or until I withdraw it

_____ _____

Signature of Patient, Parent/Legal Guardian, or Person Acting in Loco Parentis **DATE**

Authorization to Disclose Health Information

Patient Name:_____ Date of Birth:_____
Patient Address:_____

- As required by the privacy regulation, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

(Circle one)

NO -do not share my information **YES- share my information**

If YES, Dr. Kimberly Bolling may share my health information with the following person:

Name:_____ Phone Number:_____

Relationship to Patient:_____

I give Dr. Kimberly Bolling permission to leave my results or any pertinent medical information on my home voicemail or cell phone. **(Circle one)**

YES NO

My signature verifies that this request accurately reflects my wishes. It is my responsibility to notify Metropolitan Medical Group of any changes.

_____ _____

Signature **Date**

MEDICATIONS (INCLUDE DOSAGE AND DIRECTIONS)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES ☐ ***NO KNOWN DRUG ALLERGIES***

_____**Reaction:**_____ _____**Reaction:**_____

_____**Reaction:**_____ _____**Reaction:**_____

_____**Reaction:**_____ _____**Reaction:**_____

MEDICAL HISTORY LIST ANY CURRENT/PAST MEDICAL PROBLEMS OR CONDITIONS

CURRENT

_____ _____

_____ _____

_____ _____

_____ _____

PAST

_____ _____

_____ _____

_____ _____

_____ _____

(CHECK ANY THAT APPLY)

O Headache	O Chest pain	O Rashes	O Head injury	O Breast discharge
O Migraines	O Heart attack	O Birthmarks	O Memory issues	O Excessive thirst
O Weakness	O Heart murmur	O Sores	O Concussion	O Endometriosis
O Dizziness	O Heart racing	O Dry skin	O Confusion	O Irregular menses
O Weight loss	O Hypertension	O Hair growth	O Unsteady gait	O Lump in breast
O Weight gain	O Hypotension	O Hair loss	O Trouble walking	O Breast concerns
O Night sweats	O Cancer	O Back pain	O Arm weakness	O Sleep walking
O Wears Glasses	O Swollen Feet	O Neck pain	O Leg weakness	O Snoring
O Deafness	O Shortness of breath	O Arm pain	O Panic attack	O Insomnia
O Noise in Ears	O Heart Burn	O Leg pain	O Depression	O Sleep apnea
O Nose bleeds	O Change in bowels	O Arthritis	O Worry alot	O Gasping for air
O Dental Concern	O Bloody stool	O Osteoporosis	O Loss of appetite	O Restless sleep
O Double Vision	O Constipation	O Anemia	O Anxiety	O Day time drowsiness
O Eye pain	O Ulcers	O Bruise easily	O Fatigue	O _____
O Sinus Trouble	O Urine Concerns	O Stroke	O Loss of energy	O _____
O Sore throat	O Sexual difficulty	O Seizures	O Skin changes	

SURGERIES ☐ Denies any past surgeries

Type:_____ Date:_____ | Type:_____ Date:_____

Type:_____ Date:_____ | Type:_____ Date:_____

Type:_____ Date:_____ | Type:_____ Date:_____

FAMILY HISTORY **Please circle or list any health problems and causes of death if applicable**

MOTHER: Hypertension Cancer Alcohol/Drug Abuse High Cholesterol Stroke _____

FATHER: Hypertension Cancer Alcohol/Drug Abuse High Cholesterol Stroke _____

GRANDMA: Hypertension Cancer Alcohol/Drug Abuse High Cholesterol Stroke _____

GRANDPA: Hypertension Cancer Alcohol/Drug Abuse High Cholesterol Stroke _____

SISTER: Hypertension Cancer Alcohol/Drug Abuse High Cholesterol Stroke _____

BROTHER: Hypertension Cancer Alcohol/Drug Abuse High Cholesterol Stroke _____

SOCIAL HISTORY **(Please circle and list)**

- Do you drink alcohol? **YES NO** If yes, how much per week _____
- Do you smoke cigarettes? **YES NO** If yes, how much per week _____
- Do you use marijuana? **YES NO**
- Do you consume caffeine? **YES NO** If yes, how much per week _____
- Do you exercise? **YES NO** If yes, what type of exercise _____
- How many hours, on average, do you sleep at night? _____
- How would you rate your diet? **GOOD FAIR POOR**
- Do you wear seatbelts? **YES NO**
- Do you have working smoke detector in home? **YES NO**
- Current occupation if employed: _____ **RETIRED UNEMPLOYED**
- Martial status: **SINGLE MARRIED PARTNER DIVORCED WIDOWED**
- Do you have any children? If yes, how many _____
- Are you sexually active? **YES NO**
  If yes, what form of contraception? **NONE CONDOMS BIRTH CONTROL VASECTOMY**
- Is violence at home a concern for you? **YES NO**
- Do you have an advance directive (living will)? **YES NO**

BELOW FOR WOMEN ONLY

- Date of last menstrual period: _____Are your periods regular? **YES NO**
- Age of onset of period: _____ History of abnormal PAP smear? **YES NO**
- Total pregnancies _____ Number of live births _____
- Any pregnancy complications? **YES NO**

HEALTH MAINTENANCE Please record the last date you had the following, if you don't know leave blank

-Bone Density scan: _____ - Mammogram: _____

- Colonoscopy: _____ - Pap Smear: _____

- Physical Exam: _____ - PSA screening: _____

-Flu Vaccine: _____ -Covid vaccine:_____

- Pneumonia Vaccine:_____ - Tetanus Vaccine:_____

OTHER PROVIDERS **Please list your other providers if any**

- Cardiology name: _____Phone#:_____
- Gastroenterologist name: _____Phone#:_____
- Neurologist name: _____Phone#:_____
- Endocrinologist name: _____Phone#:_____
- Pulmonary name: _____Phone#:_____
- Gynecologist name: _____Phone#:_____
- _____ name: _____Phone#:_____
- _____: _____Phone#:_____

(Please circle or list)

- Do you have preferred laboratory? **QUEST LABCORP**
- Do you have a preferred radiology location?
  Community radiology Anne Arundel Diagnostic Chesapeake Imaging Washington radiology
  Other:_____

OFFICE POLICIES

In effort to continuously strive to exceed the expectations of our valued patients, we have adopted the following office policies. The fee is per patient and must be paid in advance, at the time the service is requested. This fee is not billable to your insurance carrier.

- **Copayment/Deductibles** are due at the time of services.
- **Cancellation** There will be a $25.00 charged for same day cancellations.
- **Medical Forms/Letters** There will be a $25.00 administrative fee for completion of all forms/letters. There will be a 15-30 business day turnaround time.
- **Medical Records** A copy of your medical records can be provided to you. We charge $0.76 per page fee for medical records by Maryland state law. Please allow a 30-business day turnaround.
- **Referrals** Please obtain any referrals that are needed for any upcoming appointments. Make sure you take your referral on the day of your appointment. If you misplace or lose your referral(s) you must come to the office to pick up replacements. If the office has replaced your referrals on several occasions there will be a $10 fee for the duplication of any/all referrals.
- **Prescription Refill** Any prescription needing refilled should be done at the time of your appointment (Generally a 12-16 weeks supply depending on the medication) For refills call the office number and press prescription option, leave voicemail it is checked everyday.
- **Results** It may be necessary that you make a follow up appointment to discuss your results. No abnormal results will be discussed over the telephone. NO EXCEPTIONS!

_____ _____

Signature **Date**

CRISP

Connecting Physicians With Technology to Improve Patient Care in Maryland

We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP)), will still be available to providers.

OPT-OUT FORMS AVAILABLE AT WWW.CRISPHEALTH.ORG

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ **Date of Birth:**_____

Phone: H)_____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name:

_____

Facility Address:

_____

_____

Facility Phone:_____

Facility Fax:_____

The purpose of disclosure is:

- ⑤ Change of Insurance or Physician
- ⑤ Continuation of Care (e.g., VA Med Ctr)
- ⑤ Referral
- ⑤Other_____

Dates and Type of information to disclose:

- ⑤ 2 years prior from last date seen
- ⑤ Dates Other: _____
- ⑤ Specific Information Requested:

_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: Dr. Kimberly Bolling 4000 Mitchellville rd. suite B424 Bowie MD 20716.
Phone: 301-352-0090 Fax: 301-390-6029

⑤ **Please mail records. Or** ⑤ **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative **Date**
(Guardian or Authorized Representative must attach documentation of such status.)

_____ _____

Printed name of Authorized Representative Relationship / Capacity to patient

_____

Address and telephone number of authorized representative