NORTH CAROLINA INTERNAL MEDICINE, PC
251 KEISLER DR., SUITE 300
CARY, NC 27518
CHINA K. GOLI, MD & ASWANI NAIDU, MD
TEL: (919) 851-1600 FAX: (919) 851-1666

PATIENT INFORMATION

NAME: _____
FIRST MIDDLE INITIAL LAST

DATE OF BIRTH: _____ AGE: _____ GENDER: _____

ADDRESS: _____

_____
CITY STATE ZIP

HOME PHONE: _____ ☐ Preferred Contact Number

CELL PHONE: _____ ☐ Preferred Contact Number

WORK PHONE: _____ ☐ Preferred Contact Number

OTHER PHONE: _____ ☐ Preferred Contact Number

SSN: _____ EMPLOYER NAME: _____

HOW DID YOU HEAR ABOUT US:

_____

_____

BILLING INFORMATION

☐ CHECK HERE IF THE BILLING INFORMATION IS THE SAME AS THE ABOVE PATIENT INFORMATION.

RESPONSIBLE PARTY FOR BILLS:

_____
NAME RELATIONSHIP TO PATIENT

ADDRESS: _____

_____
CITY STATE ZIP

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ OTHER PHONE: _____

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EMERGENCY CONTACT INFORMATION

PERSON TO CONTACT IN CASE OF EMERGENCY:

_____

NAME **RELATIONSHIP TO PATIENT**

ADDRESS: _____

_____

CITY **STATE** **ZIP**

HOME PHONE: _____ **WORK PHONE:** _____

CELL PHONE: _____ **OTHER PHONE:** _____

NEXT OF KIN (☐ Same as above)

NEXT OF KIN: _____

NAME **RELATIONSHIP TO PATIENT**

ADDRESS: _____

_____

CITY **STATE** **ZIP**

HOME PHONE: _____ **WORK PHONE:** _____

CELL PHONE: _____ **OTHER PHONE:** _____

I hereby assign and transfer over to North Carolina Internal Medicine, PC all my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. *I understand that I am financially responsible for all charges whether or not they are covered by insurance*.

PATIENTS PRINTED NAME: _____

PATIENTS SIGNATURE: _____

DATE: _____