Northwest Arkansas EMG Clinic
Miles M. Johnson, M.D.

PATIENT INFORMATION (please print)

Patient_____SS#_____
First Middle Last

Address_____

City_____ State_____Zip Code_____

Home Phone_____Birthday____/____/_____ Age_____

Work Phone_____Your Employer_____

Cell Phone_____Sex____ Marital Status_____

Email Address_____

Responsible
Party/Insured:_____Employer_____
Must have SS# and DOB of Insured
Insured Social Security # _____Insured Birthdate____/____/_____

In case of emergency notify:_____Phone_____

Insurance Information

Primary Insurance Company_____
Address of Company:_____
Name of Insured_____

Insured ID #_____Group#_____

Secondary Insurance Company_____
Address of Company:_____
Name of Insured_____

Insured ID#_____Groups#_____

Accident: Work_____Auto_____Personal Injury_____Date of Injury_____

Insurance Authorization and Assignment

I request that payment of authorized Medicare, Medicaid, Commercial Carrier, Workman's Compensation, or VA benefits on my behalf be made to Northwest Arkansas EMG Clinic for any services provided to me by Dr. Johnson. I authorize Dr. Johnson to release to the Health Care Administration and its agents any information needed to determine benefits payable for related services. I understand that I am responsible for any deductible, co-pay, or services not covered by my insurance carrier. I also authorize the physician to release any information required by my insurance company and/ or another physician.

_____ _____
Patient Signature or Legal Guardian (if minor) Date

_____ _____
Spouse Signature (if applicable) Date

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Financial Policy

This notice explains any financial information regarding payment of services performed by NWA EMG Clinic involving you, and any responsibilities our services will extend to any insurance company.

Insurance Coverage

We will file a claim to the insurance company and any portion that the insurance does not cover will be your responsibility.

Workers compensation

If you have workers compensation we will be happy to file the claim for you. We must have all information necessary to file. If for some reason your work comp is denied, then the balance becomes your responsibility. If you wish us to file it to your commercial insurance, we must be informed by you with all the necessary information, otherwise the balance again becomes your responsibility.

Personal Injury or MVA

We may file these claims for you if we have all the information necessary. If it is a third party claim you may be asked to help us in the process of retaining information. If we do not get all the information needed then the balance will be your responsibility until we get the necessary information. Also, to be able to hold this account, you will be required to pay a small monthly payment until the account is paid or settled. If a settlement is reached and the payment is sent to you, then you will be responsible to pay us the balance on your account. Filing fees may apply.

Medicaid

If for some reason Medicaid denies payment on any portion of our services,
then we will file an extension of benefits as a courtesy to you. Then, if the extension is denied, the remaining balance is your responsibility.

Allowable forms of payment:	Cash, check, money order, or credit card.
Insufficient funds charge:	There will be a $25.00 charge for any insufficient funds check.

I hereby acknowledge that I have been presented with a copy of "Northwest Arkansas EMG Clinic Notice of Privacy" policy and give permission to release my medical records to myself at my request. You have the right to request that we communicate with you in confidence regarding your personal and health information. Please contact Carol Groves 479-251-8055 if you have any questions, requests or wish to file a complaint.

We appreciate you taking the time to read this information and will be happy to discuss any aspect of our financial policy. If you have any questions please let us know.

Patient Signature:_____ **Date**_____
Spouse Signature:_____ **Date**_____

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Medical History

Patient Name: _____SS#_____

Height: _____Weight:_____Age:_____Date of Birth_____

Personal Physician: __Dr._____
Full name City, State

Consultation & EMG Test Requested By Dr. _____
Full name City, State

Date of return visit to Requesting Physician: _____

Have you seen Dr. Miles Johnson for EMG/NCV in past?_____If so, date_____

Please Circle all that apply:

Dominant Hand:		Right	Left		
Main Problem Area:		Neck	Low Back	Right Arm	Left Arm
Right hand	Left Hand	Right Leg	Left Leg	Right Foot	Left Foot
Symptoms:	Pain	Numbness	Tingling	Burning	Weakness
Quality of Symptoms:		Mild	Moderate	Severe	

How long have you had symptoms? **MUST BE A DATE**_____/____/_____

Result of: Unknown Accident Injury Type of Accident/Injury:_____

IF Motor Vehicle Accident, STATE in which MVA occurred:_____

Are the symptoms you are having: Increasing Decreasing or No Change in Severity

Are the symptoms: Constant or Intermittent

(Females) Are you pregnant? Yes No

Diabetes: ☐ No ☐ Type 1 ☐ Type 2 ☐ Insulin Dep. ☐ Oral Meds

Thyroid Disease: ☐ No ☐ Hypothyroidism ☐ Hyperthyroidism

Do you have: Heart Valve Replacement? _____ Defibulator?_____

Have you been diagnosed with: Fibromyalgia?___ Parkinson's?___ MS?___ Arthritis?_____

Current Conditions/Illnesses:_____[]None-Healthy

Have you had Spinal or Extremity Surgeries? (please list):_____

Medications: _____

Allergies to Medications:_____

Family Members with Heart Disease:_____ Cancer:_____Diabetes:_____

Do you smoke? Yes ____ No ____ How Much _____

Do you drink alcohol ? Yes ____ No ____ How Much _____

Occupation type (be specific):_____

Exam (reserved for office use)

Neck _____ DTR's _____
Back _____ Extremity_____
Motor _____ Gait _____
Sensory _____

Visitor in room_____Location_____Emp_____

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Symptom Evaluation

Patient Name:_____

Please circle all that apply:

Constitutional:	Fever	Fatigue	Night Sweats	Weight Loss
HEENT:	Headaches	Diplopia	Swallowing problem	
Respiratory:	Cough	Hemoptysis (cough & blood)		
Cardiovascular:	Chest pain	Palpitations		
Vascular:	Claudication (calf pain with ambulation)			
GI:	Nausea	Vomiting	Diarrhea	Constipation
	Incontinence of bowel			
GU:	Incontinence of bladder			
Metabolic/Endocrome:	Generalized weakness	Heat/Cold intolerance		
Dermatology:	Rashes			
Muscloskeletal:	Joint pain	Muscle pain	Weakness	
Hemotologic:	Bruising/Bleeding			
Neurological:	Pain	Numbness	Tingling	Weakness
	Balance abnormalities	Vision change	Headaches	