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_____
( ) permission to text
Email Address_____
( ) permission to email
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_____
Attorney on Injury case/phone number:_____

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 authorize the physician to release any information required by my insurance company and/ or another physician. I acknowledge the offer of Notice of Privacy Practices. I give permission to release my medical records to myself at my request .I authorize treatment provided by Dr. Miles M. Johnson.
( ) Permission to discuss my medical info with _____

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

_____ _____
Spouse Signature (if applicable) (Signature on File) Date