

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