New Patient Form-EMG

New Patient Registration Form

Please fill out this form completely. The following information will help us in providing you the best medical care and treatment possible.

Patient Information

First Name

Middle Initial

Last Name

How old are you?

SSN

Sex

Mailing Address

City

State

Zip Code

Home Phone (if different than cell)

Work Phone

Cell Phone

Date of Birth

Marital Status:

Name of Employer

Alternative Contact information

Alternative Contact Name

Alternative Contact Number

Relationship

~~Primary Insurance Information~~

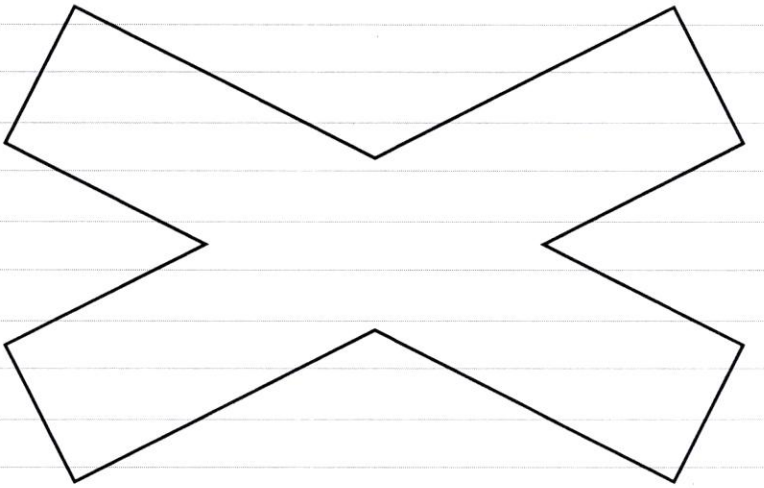
~~Primary Insurance Name~~

~~Policy ID~~

~~Group ID~~

~~Policy Holder's Name~~

~~Policy Holder's DOB~~



Medical History

Height:

Weight:

Which is your dominant hand?

Do you have a personal history of Diabetes?

Are you currently taking any blood thinners? (i.e., Coumadin, Warfarin, Xarelto, Aspirin, etc.)

Reason for visit/chief complaint/symptoms

Date symptoms started. Please try to be as specific as possible.

Please list past medical history/illness

Please list any MEDICATION allergies

Have you ever had any surgery on your neck, back, arms or legs? If yes, please list.

Occupational/work history

Job title/Duties:

Financial Consent *Please sign below.

I authorize Mark R. Killman, M.D. to release information regarding my medical care to my insurance company to process my claim. I authorize payment of benfits to Mark R. Killman, M.D. for all services rendered. I understand that I will be responsible for any balance not covered by my insurance company. In the event my account should go to collection, I understand that I will be responsible for all collection and legal fees. *

Date:

Patient Consent for Use and Disclosure Of Protected Health Information *Please sign below.

I HEREBY GIVE MY CONSENT FOR MARK R. KILLMAN, M.D., P.C. TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT ME TO CONDUCT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS. I hereby acknowledge my right to review the Privacy Practices for Mark R. Killman, M.D., P.C. prior to signing this consent. With this consent, Mark R. Killman, M.D., P.C. may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. With this consent, Mark R. Killman, M.D, P.C. may mail to my home or other alternative location any items that assist the practice in conducting treatment, payment, and healthcare operations, such as appointment reminder cards and patient billing statements. By signing this form, I am consenting to Mark R. Killman, M.D., P.C.'s use and disclosure of my protected health information to conduct treatment, payment, and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke, Mark R. Killman, M.D., P.C. may decline to provide treatment to me.

Date: