Mount Vernon Rehabilitation Medicine Associates

EMG Patient Registration Form

Demographic Information

Last Name:_____ **First Name:**_____ **MI:**_____

Date of Birth:_____ **Soc Sec No:**_____ **Gender:** □**Male** □**Female**

Height:_____ **Weight:**_____ **Dominant Hand:** □ **Left** □**Right**

Home Address:_____ **City:**_____ **State:**_____ **ZIP:**_____

Home Phone:_____ **Mobile Phone:**_____

Email Address:_____

Emergency Contact Person:_____ **Emergency Contact Phone #:**_____

Information about Physicians

Name of Doctor who Referred you for the test:_____

Name of your Primary Care Doctor:_____

List any other doctors who should receive results of the test:_____

_____

Medications and Allergies

List all Medications you are allergic to:_____

_____

List all Medications you are taking (please include dose and for how long you have been taking each)
(Please be sure to include vitamins and supplements
[As an alternative, you may attach a list of your medications.]

_____

_____

_____

_____

_____

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_____

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Please describe your symptoms and/or the reason you are having this test:

_____
_____
_____
_____
_____
_____
_____
_____

For how long have you had this problem? _____

If this problem began after an injury, please describe the injury:

_____
_____
_____
_____

If have had prior EMG(s), please list the approximate date(s) and the name(s) of the doctor(s) who performed the test(s):

_____
_____
_____

List your current and prior medical conditions:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

List your prior surgeries and approximate dates:

_____
_____
_____
_____
_____
_____
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_____
_____
_____

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Smoking Status:
□ Never Smoked
□ Former Smoker
□ Current Every Day Smoker
□ Current Heavy Smoker
□ Unknown if Ever Smoked
□ Smoker, Current Status Unknown
□ Current Some Day Smoker
□ Current Light Smoker

Alcohol Use:
□ Never
□ Rare
□ Weekly
□ Daily
□ Heavy Use
□ Current Light Smoker

Problematic Drug Use:
□ Never
□ Prior
□ Current

Employment Status:
□ Employed □ Student □ Retired □ Homemaker □ Unemployed □ Disabled

Occupation:_____

Ethnicity/Race:
□ American Indian or Alaska Native
□ Hispanic or Latino
□ Asian
□ Black or African American
□ Native Hawaiian or Pacific Islander
□ White
□ Decline to Answer
□ Other:
_____

Preferred Language:
□ English
□ Spanish
□ Other:
_____

Is there anything else you would like us to know?

_____
_____
_____
_____

Consent regarding payment/insurance:

I herby authorize Mount Vernon Rehabilitation Medicine Associates to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of all information necessary to secure payment of benefits to my insurance company or health care program.

I understand that I am financially responsible for any and all charges on my account whether or not paid by my insurance plan.

Patient Signature:_____ **Date:**_____