NEUROLOGY &
SLEEP CLINIC PLC.

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EMG Intake Form

Date: _____

Name:_____DOB:_____Age:_____

Height:_____Weight: _____

Handedness: Right_____Left _____

Referring Physician:_____Date symptoms began: _____

Primary Care Physician:_____Pharmacy: _____

Briefly describe your present symptoms (problems):_____

_____

Advanced Directive (DNR/Living Will/POA):_____

Any Recent Falls_____Yes____No

MEDICATIONS:

Name of Drug	Dose	Directions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies:	Drug	What reaction?
	_____	_____
	_____	_____
	_____	_____

Patient Number_____

Mercy Plaza, Suite 153 * 1225 S. Gear Avenue * West Burlington, IA 52655 * Phone: 319-754-4400 * Fax: 319-754-4412
More Info at www.NeurologyandSleepClinic.com

(updated 1/23)

PAST MEDICAL HISTORY:

Do you have or have you had these medical conditions:

___	Fainting	___	Diabetic Retinopathy
___	Heart disease	___	Tremor
___	Atrial fibrillation	___	Autoimmune disease
___	CHF	___	Osteoarthiritis
___	Hypertension	___	Depression
___	High Cholesterol	___	Anxiety disorder
___	Diabetes	___	Migraine/headache
___	Thyroid Dysfunction	___	Epilepsy
___	COPD	___	Stroke syndrome
___	Asthma	___	Peripheral Neuropathy
___	Cancer	___	Dementia
___	GI Disorder	___	Restless Legs Syndrome
___	Kidney disorder	___	Obstructive sleep apnea

Other: _____

_____

PREVIOUS OPERATIONS:

____	Carotid artery surgery	____	Hysterectomy
____	Heart Valve replacement	____	Appendectomy
____	Carpal tunnel release	____	Back Surgery
____	Knee replacement	____	Brain surgery
____	Hip Replacement	____	Tonsillectomy
____	Gall bladder removal	____	Pacemaker

Other surgery:

_____

_____

Patient Number_____

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PATIENT REGISTRATION

Date: _____

Name:_____SS#:_____

Address:_____

City:_____State:_____Zip: _____

Sex: [ ] M [ ] F Age:_____ Birth date: _____

Marital status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced

Pharmacy:_____Race:_____

Personal E-mail: _____

Patient Employer:_____Occupation:_____

Home Phone:_____Cell Phone:_____Work Phone _____

POA (Power of Attorney):_____Phone:_____

Name of spouse/next of kin that we may contact:_____Phone: _____

INSURANCE INFORMATION:

(Patient is responsible for completion of insurance information below.)
Is today's visit the result of a motor vehicle accident? [ ] Yes [ ] No: Date ofinjury: _____
Is today's visit the result of a personal injury? [] Yes [] No: Date ofinjury: _____
Is today's visit the result of a work injury? [ ] Yes [ ] No Date of Injury:_____Claim # _____

Primary Ins._____Phone:_____

Primary Ins Address: _____

Policyholder's Name:_____Employer:_____

SS#:_____Birthdate:_____Relationship to patient: _____

Address (if different from patient): _____

Group #:_____Policy #: _____

Secondary Ins:_____Phone:_____

Secondary Ins Address: _____

Policyholder's Name:_____Employer:_____

SS#:_____Birthdate:_____Relationship to patient: _____

Address (if different from patient): _____

Group #:_____Policy #: _____

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DISCLOSURE:

I authorize the following means to communicate my health and/or account information:

Persons:_____Phone: _____

_____Phone:_____

Voicemail and/ or Text messages can be left at: (_____) _____

E-mails may be sent to the address on file, or _____

_____ _____

Patient (or representative) Signature Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICES:

I have seen and understand the Burlington Neurology & Sleep Clinic, PLC's Notice of Privacy Practices.

ASSIGNMENT AND RELEASE:

I, the undersigned, certify that I or my dependent assign directly to Burlington Neurology & Sleep Clinic, PLC all insurance benefits, if any, otherwise payable to me for services rendered. As a courtesy, Burlington Neurology & Sleep Clinic, PLC will bill my insurance, and it is my responsibility to ensure timely payment. Acceptance of my insurance card in no way constitutes the clinic's participation with my carrier. I understand that it is my responsibility to verify insurance coverage, eligibility and participation of this clinic and/or its doctors with my insurance carrier. I also understand that I am financial responsible for all charges whether paid or not by insurance, plus any finance charges which accrue at 18% annually on the balance not paid within 30 days of the statement date. There will be a charge of $25.00 for all returned checks. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions and communications.

I acknowledge that failure to sign this form does not release me from financial responsibility, as outlined below, for services I receive from this clinic and its physicians.

CONTINUITY OF CARE:

I give my permission to Burlington Neurology & Sleep Clinic, PLC to release my records for the continuity of my care and/or to refer me for further treatment.

I, the undersigned, have read and understand the above information.

_____ _____

Patient (or representative) Signature Date

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare or Medicare Advantage (any plan) benefits be made either to me or on my behalf to BN&SC, PLC and all its providers, for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 on the CMS-1500 form, or else on other approved claim forms or electrically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charges and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. I authorize the use of this signature on all insurance submissions, including Medicare and all of my secondary insurances.

_____ _____

Beneficiary (policy holder) Signature Date