CELEBRATING 30 YEARS

Northeast Rehab

Spine • Sports • Neuro • Pain

Thank you for choosing

Northeastern Rehabilitation Associates

-www.nerehab.com-

Arrival Time vs Appointment Time for EMGs

You will be given an Appointment Time for the EMG and an ***Arrival Time*** of **30 minutes prior.**

EMGs require a minimum of 30 minutes to complete. Our goal is to have you in the exam room as close to your appointment time as possible. By arriving 30 minutes prior, this allows us to complete the check in process and provide the physician the time he/she needs to complete the EMG study.

If you are not here 30 minutes prior to the EMG appointment time, we may need to reschedule your appointment.

Thank you.
The Staff and Physicians of Northeast Rehab

Patient Information

Patient Name: _____

Date of Birth: _____ Social Security #_____ Sex: ☐ M ☐ F

Race: ☐White ☐Black/African American ☐American Indian/Alaska native ☐Asian
☐Native Hawaiian/other Pacific Islander ☐Other _____

Ethnicity: ☐Not of Spanish/Hispanic descent ☐Spanish/Hispanic Primary Language:_____

Cell #: _____ Home#: _____ Work #:_____

Address: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact_____ Phone: _____

Person(s) we may speak with regarding your medical/financial information should the need arise:

Name: _____ Relation: _____

Primary Insurance Information

Name of Insurance Company_____

Policy Number_____ Group Number _____

Policyholder Information - If you are the policyholder, check this box ☐ and skip to the next section.

Name of Policy Holder:_____ Relationship to Patient: _____

Date of Birth: _____ Social Security #_____ Phone: _____

Address: _____

Employer: _____

Secondary Insurance Information

Name of Insurance Company_____

Policy Number_____ Group Number _____

Policyholder Information - If you are the policyholder, check this box ☐ and skip to the next section.

Name of Policy Holder:_____ Relationship to Patient: _____

Date of Birth: _____ Social Security #_____ Phone: _____

Address: _____

Employer: _____

Work / Auto Related Injury

Is this the result of an accident: ☐Auto ☐Work Date of Injury/Accident: _____

Insurance Carrier:_____ Contact Name/Phone:_____

Address:_____

Claim Number:_____ Insurance ID Number_____

If Auto Accident, State where injury occurred: _____

If Work Injury, Employer Name:_____

Employer Address: _____

County: _____ Contact Name/Phone: _____

Address where injury occurred: _____

Job Title: _____ Job Duties: _____

Adjuster Handling Claim (Name/Phone): _____

Attorney Handling Claim (Name/Phone): _____

Patient Name: _____ **DOB:**_____

Medication Intake Sheet

Please list **ALL** medications taken on a daily basis.
This includes all **vitamins, herbals and over-the-counter medications**.

Medication Name	Dose / Strength	Times taken per Day	Prescribing Doctor	Reason for Taking Medication

Please list any Medications you have tried in the past for this current problem:

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed**:** _____

Please list ALL Medication Allergies:

_____

_____

Pharmacy Name _____ **Phone Number**_____

Pharmacy Address (if known): _____