



Saint Vincent Catholic Medical Centers Neurology Services Booking Form

<p><u>Electromyography and Nerve Conduction Studies (EMG)</u></p> <p>Fax: (212) 604- 8693 Phone: (212) 604- 8684</p>	<p><u>Electroencephalography (EEG) Evoked Potentials (EP)</u></p> <p>Fax: (212) 604- 2333 Phone: (212) 604- 7766</p>
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“*” Fields are **required** as they are key data elements to initiate pre-registration.
Complete other fields when information is available.

Patient Name*: _____, _____		Sex*: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Last	First		
Date of Birth*:	SSN:	MRN:	
Patient Address*:			
Home / Cell Telephone #*:			
Guarantor / Legal Guardian:		Best time to call:	
Employer:		Work Telephone #:	
Interpreter Needed:		Language:	
Emergency Contact:		Tel #:	Relationship:
PROCEDURE			
Referring Physician*:		Tel #:	Fax #:
Attending Physician UPIN # or NPI #*:			
Schedule Date (if known):			
Procedure(s)*: <input type="checkbox"/> EMG <input type="checkbox"/> EEG <input type="checkbox"/> EP			
Diagnosis / ICD-9*:	1:	2:	3:
INSURANCE			
Insurance Company*:			
Policy #*:	Group #:	Ins. Tel #:	
Subscriber Name*:	Relationship to Patient:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse <input type="checkbox"/> Child
Subscriber SSN:	Subscriber Date of Birth:		
Secondary Ins:	Policy #:	Ins. Tel #:	
Subscriber Name:	Relationship to Patient:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse <input type="checkbox"/> Child
Pre-cert # if Applicable*:			
Name of person at Ins. Company issuing Pre-Cert:		Tel #:	Date obtained:
Date Faxed: _____ By: _____			
To Be Considered an Rx, Sign Here:			Date: