EMERALD COAST
NEUROLOGY

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☐ DAVID BEAR, DO ☐ DANIEL ROSS, DO ☐ HENRY PORTER, MD ☐ FIRST AVAILABLE

DATE: _____ REFERRAL PHYSICIAN: _____

PHONE: (_____) _____ x _____ FAX: (_____) _____

OFFICE CONTACT: _____ EMAIL: _____

PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____

SOCIAL SECURITY #: _____ GENDER: ☐ MALE ☐ FEMALE

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: (_____) _____ ALT PHONE: (_____) _____

PRIMARY INSURANCE: _____ ☐ HMO ☐ PPO

POLICY #: _____ GROUP #: _____

SECONDARY INSURANCE: _____ ☐ HMO ☐ PPO

POLICY #: _____ GROUP #: _____

AUTHORIZATION #: _____

DIAGNOSIS: _____

☐ NEUROLOGY CONSULTATION ☐ SLEEP CONSULTATION ☐ BOTULINUM TOXIN THERAPY CONSULTATION

☐ STANDARD EEG ☐ 24HR EEG ☐ 48HR EEG ☐ 72HR EEG

☐ EMG/NCV UPPER EXTREMITIES
LEFT RIGHT BI-LATERAL

☐ EMG/NCV LOWER EXTREMITIES
LEFT RIGHT BI-LATERAL

PLEASE INCLUDE: ☐ OFFICE NOTES ☐ COPY OF INSURANCE CARD/DRIVER'S LICENSE ☐ COPY OF AUTHORIZATION ☐ RADIOLOGY REPORTS