Brain Science Technologies
4482 Barranca Pkwy #240
Irvine, CA 92604

Demographics Form

Patient Name: _____ Date of Birth: _____

Telephone: _____

Email: _____

Parent or Caregiver name: _____

Address: _____

City: _____ State: _____ Zip: _____

Referring Physician: _____

Fax: _____

Reason for EEG

referral: _____

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Medications (please list dosage):

_____

Prior EEG: _____

Report attached: Y ◯ N ◯

Notes or Medical History:

Insurance: _____

Social Security # for Policy Holder: __ __ __ - __ __ - __ __ __ __

Birth Date of the Subscriber: _____

Responsible Party: _____

Relationship: _____

A complete patient profile will consist of this demo sheet, a copy of your insurance card (both sides please) and a prescription from your physician. Once we have the above documents, we will be happy to have you scheduled within (7) days.

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____ _____

Home Phone:_____ Work/Cell Phone: _____

The above-named patient authorizes the release of their medical records to:

Brain Science Technologies
4482 Barranca Pkwy #240
Irvine, CA 92604

Attn: Billing Department
Phone: (619) 480-0080 x 4
Fax: (949) 333-5086
Email: tracyr@billingandcodingservices.com

Please release medical records, including history and physical, presenting symptoms and chart notes pertaining to the necessity of the EEG. Please include any former EEG reports if applicable.

I understand that by signing this form, I am authorizing the use or disclosure of protected health information as indicated above.

I have read the above foregoing Authorization of Release of Medical Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____

Signature of Patient / Representative Date

_____ _____

Print Name Relationship to Patient