

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

Demographics Form

Patient Name:	Date of Bir	Date of Birth:		
Telephone:		_		
Email:				
Parent or Caregiver name:				
Address:				
City:	State:	Zip:		
Referring Physician:				
Fax:				
Reason for EEG				
roforral:				



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Medications (please list dosage):

rior 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	side

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	e/Zip:				
Home Phone:		Work/C	ell Phone:		
	The above-named	patient authorizes the re	lease of their medical records	to:	
		Brain Science Tech 4482 Barranca Pky	<u>-</u>		
		Irvine, CA 92604			
		Attn: Billing Depa Phone: (619) 480-0 Fax: (949) 333-5	080 x 4		
	Ema	il: tracyr@billingandco	dingservices.com		
			ohysical, presenting symptor clude any former EEG repor		
	d that by signing thi as indicated above		g the use or disclosure of pro	otected health	
	ge that I am familia		ease of Medical Information tand the terms and condition		
x					
Signature	e of Patient / Rep	oresentative		Date	
Print Nar	ne		Relationship to Patien	t	