Stoll NEURODIAGNOSTICS

Patient Registration

Date: _____

Patient Information (please print)

Name: _____

Address: _____

City, State, & Zip: _____

Date of Birth: _____**Age:** _____**Sex:** _____

Marital Status: _____ **Spouse's Name:** _____

Cell Phone: _____

Home Phone: _____

Email Address: _____

Referring Doctor: _____

Primary Care Doctor: _____

Additional Doctors to send EMG-NCS Report: _____

Height: _____ **Weight:** _____

Are you currently living in a skilled nursing home or rehabilitation facility? (Circle) Yes No

Permission to send E-mailed reports/Billing Statements (Circle) Yes No

Emergency Contact:

Name: _____

Cell Phone: _____

Patient Signature: _____ **Date:** _____/_____/_____