

**HARTFORD NEUROLOGY, LLC  
EMG REGISTRATION**

Please take a few minutes to complete this New Patient Registration form to the best of your knowledge. Bring these forms with you on the day of your appointment. Thank you.

**PATIENT INFORMATION**

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Spouse/Guardian/Other \_\_\_\_\_ Occupation \_\_\_\_\_

(Circle one)

Employer \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

**Work Related Injury?** Yes \_\_\_\_\_ No \_\_\_\_\_      **Auto Accident Injury?** Yes \_\_\_\_\_ No \_\_\_\_\_

**\*If answered yes, is there an existing claim?** Yes \_\_\_\_\_ No \_\_\_\_\_

**INSURANCE/BILLING INFORMATION**

**Primary Insurance Company** \_\_\_\_\_

Address \_\_\_\_\_

Name of Insured \_\_\_\_\_ D.O.B. \_\_\_\_\_ Insured SS# \_\_\_\_\_

Relationship to \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_ Copay \_\_\_\_\_

**Secondary Insurance Company** \_\_\_\_\_

Address \_\_\_\_\_

Name of Insured \_\_\_\_\_ D.O.B. \_\_\_\_\_ Insured SS# \_\_\_\_\_

Relationship to \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_ Copay \_\_\_\_\_

**MEDICAL INFORMATION**

**Referring Physician** \_\_\_\_\_ Referring Dr. Phone Number \_\_\_\_\_

Address \_\_\_\_\_

**Primary Care Physician (PCP)** \_\_\_\_\_ PCP Phone Number \_\_\_\_\_

(If different from above)

Address \_\_\_\_\_

Any known allergies? \_\_\_\_\_

**Pharmacy** \_\_\_\_\_ Phone Number \_\_\_\_\_

Have you ever seen a Neurologist in the past? \_\_\_\_\_ If yes, who/where? \_\_\_\_\_

I hereby authorize the release of medical information and/or payment directly to Hartford Neurology, LLC.

**Signature** \_\_\_\_\_ **Today's Date** \_\_\_\_\_