THE NEUROLOGY GROUP
EEG/EPSTUDIES•EMG/NCV•VASCULAR STUDIES
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DEMOGRAPHIC SHEET

Date: _____

Patient Name_____DOB: _____

Current Mailing Address: _____

Primary Phone Number: _____

Secondary Phone Number: _____

Primary E-mail Address: _____

Race/ Ethnicity: _____

Primary/Referring Provider: _____

Have you ever smoked before: YES? NO?

If yes how long ago? _____

Frequency: 1-5 6-10
Half a pack a day 1 pack a day

List an Emergency Contact: _____
Relationship:_____
Home: _____
Cell: _____

Pharmacy Name: _____
Address:_____
City & Zip code: _____
Phone # & Fax #: _____