Deborah T. Combs Cantrell, M.D.

Elite Neuroscience Center

Please make sure all forms are completed prior to your appointment.

Non-completion of forms may affect your scheduled appointment.

Your visit is scheduled for: _____

Please arrive 15 minutes prior to your appointment

At the following location:

Vista Point

405 State Highway 121 Bypass (Sam Rayburn Tollway)

Building A Suite 150

Lewisville, TX 75067

Telephone: 469-312-1130

Fax: 972-459-7221

Email: info@elite-neuro.com

Website: www.elite-neuro.com

***Please DO NOT use a Car Navigation System, it will take you to the wrong location.**

May use Google maps, Waze, Maps*

Please bring paper copies of any recent medical records needed for your consultation. We will not accept cd, usb, or emails of medical records.

Our office requires 24 hour notice of any appointment change or cancellation. A fee is charged to patients who cancel less than 24 hour notice, as well as patients who do not show for their scheduled appointment.

Thank you for your cooperation in the coordination of your medical care.

Deborah T. Combs Cantrell, M.D., P.A.

Patient Information Form

Please complete the following questions in the spaces provided. Attach additional information if necessary.

1. Patient's Name_____ Male or Female
   Address_____
   City _____State _____ Zip Code _____
   Phone_____ Alternate Phone_____
   Social Security Number_____ Date of Birth_____
   Occupation _____ Marital Status: SINGLE MARRIED DIVORCED WIDOWED

2. Name of Policy Holder (write "same" if same as patient above)_____
   Address if different than Patient _____
   Social Security Number _____Date of Birth_____

3. Employer of Policy Holder _____
   Insurance Carrier_____
   Identification Number _____Group Number_____
   Secondary Insurance _____

4. Are you covered by Medicare? _____ if yes, please list correct number: _____

5. Have you applied for Social Security Disability or are you receiving already? _____

6. Who referred you to this office? _____
   Name of your primary care physician_____
   Phone number of physician _____

7. Pharmacy's Name and address _____
   Phone number _____

8. In case of an emergency, please list relatives or friends to contact.

Name	Relation	Phone

I understand that Deborah T. Combs Cantrell, M.D., P.A. or one of her agents will file my primary insurance. I hereby authorize this office to furnish medical information to insurance agencies if necessary to file my claim. I also understand that if my insurance claim is not paid in 90 days, I am fully responsible for payment of any and all charges.

Signature_____ Date_____

Deborah T. Combs Cantrell, M.D., P. A.

Medical Information Form

Part One

Patient Name _____ DOB _____ Date _____

Please completely fill out the following pages regarding the medical condition of yourself and your family. Completing these forms will greatly assist in your care, and these pages will become part of your confidential medical records.

1. Why are you seeing a Neurologist today _____
   _____
   _____

2. Please list your past and present medical conditions. _____
   _____
   _____
   _____
   _____
   _____
   _____

3. Have you ever been hospitalized for an illness/surgery? _____ If yes, please list below.
   Date Reason
   _____
   _____
   _____
   _____

4. Are you allergic to any medications? _____ List and explain the reaction below.
   Name Type of reaction When did it occur?
   _____
   _____
   _____
   _____

Thank you for taking the time to fill out these forms regarding your health and medical history. The information will be of assistance in evaluating your condition and forming a plan of treatment. The physician cannot be responsible for pertinent information that has been omitted. Please sign below.

The information that I have provided is true to the best of my knowledge and is as complete as possible.

Signature (of person completing forms): _____ Date: _____

Print Name: _____

Physicians Initials _____

Deborah T. Combs Cantrell, M.D., P.A.

Medical Information

Part Two

Patient Name _____ DOB _____ Date _____

5. Do you smoke? ___If yes, how much per day? Cigarettes _____ Cigars _____Pipes _____
If you are a former smoker, when did you quit? _____
How much did you smoke and for how long? _____

6. Do you drink alcoholic beverages? _____ If yes, What age did you start? _____

7. Do you use any recreational drugs? _____ If yes, What age did you start? _____

8. Have you ever had any problems with alcohol, drugs or substance abuse? _____
If yes, please explain: _____

9. Have you ever been diagnosed or treated for sexually transmitted diseases? _____
If yes, please explain: _____

10. Have you been diagnosed with the Human Immunodeficiency Virus (HIV or AIDS)? _____
Do you have reason to suspect that you have had intimate contact with persons with HIV? ____

11. Please give the date of your last: Blood Test _____ TB Test _____ HIV Test _____
Chest X-Ray _____ EKG _____ Eye Exam _____ Pap Smear _____

12. Have you ever received a blood transfusion? _____ If yes, when? _____

13. Have you recently undergone any other medical testing? ____If yes, please circle below:

MRI Scan CT (CAT) Scan Arteriogram or Angiogram
EMG or Nerve Conduction Echocardiogram (sonogram of heart)
Carotid Doppler (sonogram of arteries in neck) EEG

Please list any other recent testing not listed above: _____
_____
_____

14. Are you pregnant or do you have reason to suspect that you may be pregnant? _____
If you are pregnant, what is your approximate due date? _____

The information that I have provided is true to the best of my knowledge and is as complete as possible.

Signature (of person completing forms): _____ Date: _____

Print Name: _____

_____

Deborah T. Combs Cantrell, M.D., P.A.

Medical Information Form

Part Three

Patient Name _____ DOB _____ Date _____

15. How many brothers or sisters do you have? _____Do they have any neurological problems? _____

16. If your parents are not living, please give the cause of their death and age at time of death:

_____

_____

17. Do your children have any health problems? _____

_____

18. Please circle below if **anyone in your family** has suffered from any of the listed medical conditions. Briefly give details in space provided. Attach additional pages if needed.

Stroke	
Brain Aneurysm	
Mental Retardation	
Heart Attack	
High Blood Pressure	
Diabetes	
Seizures	
Muscular Dystrophy	
Other Muscle Disease	
Disease of Peripheral Nerves	
Mental Illness	
Tuberculosis	
Thyroid Disease	
Lung Disease	
Anemia	
Cancer	
Stomach Problems	
Bleeding Tendency	
Kidney Disease	

19. Please list any other facts about your health that you think the doctor should know:

_____

_____

The information that I have provided is true to the best of my knowledge and is as complete as possible.

Signature (of person completing forms): _____ Date: _____

Print Name: _____

Physicians Initials _____

Deborah T. Combs Cantrell, M.D., P.A.

Patient Symptom Inventory

If you have experienced any of the following symptoms *within the past year* please briefly describe in the space provided.

Patient Name _____ DOB _____ Date_____

Headache	
Neck Pain	
Low Back Pain	
Pain in a Particular Arm or Leg	
Sensory Loss or Tingling in Arm or Leg	
Blurred or Double Vision; Blindness	
Ringing in Ears	
Dizziness or Vertigo	
Impaired Speech	
Difficulty Swallowing	
Trouble Walking	
Falling Down	
Weakness All Over	
Passing Out	
Spells of Altered Awareness	
Seizures	
Memory Loss	
Hallucinations	
Depression	
Trouble Speaking	
Loss of Appetite	
Abdominal Pain	
Unexplained Weight Loss	
Nausea or Vomiting	
Persistent Diarrhea or Constipation	
Blood in Stool or Urine	
Incontinence of Urine or Stool	
Pain or Burning in Urination	
Sexual Dysfunction	
Chest Pain	
Shortness of Breath	
Palpitations or Rapid Heart Rate	
Congestion or Sinus Problems	
Recent Cold or Flu	
Prolonged or Frequent Fevers	
Night Sweats	
Persistent Cough	
Skin Rashes	
Ulcers in Mouth or on Skin	
Changes in Skin Moles	
Loud Snoring	
Trouble Sleeping	
Daytime Sleepiness	
Joint or Bone Pain	

The information that I have provided is true to the best of my knowledge and is as complete as possible.

Signature (of person completing forms): _____ Date: _____

Print Name: _____

Physicians Initials _____

Deborah T. Combs Cantrell, M.D., P.A.

MEDICATION LOG

Patient Name: _____ DOB: _____ Date: _____

Are you allergic to any medications? _____ List and explain the reaction: _____

_____

_____

Please list any prescriptions or over the counter medications you are currently taking below.

NAME	STRENGTH	HOW OFTEN?	FOR HOW LONG?

The information that I have provided is true to the best of my knowledge and is as complete as possible.

Signature (of person completing forms): _____ Date: _____

Print Name: _____

Physicians Initials _____

Deborah T. Combs Cantrell M.D., P.A.

GENERAL CONSENT FOR TREATMENT

I, knowing that I am suffering from a condition requiring diagnostic, medical treatment do hereby voluntarily consent to such procedures and care, under the general and specific instructions of your doctor, the doctor's assistant designee as is necessary in his/her judgment.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments or examination.

_____ _____

Patient's Signature DATE

Deborah T. Combs Cantrell M.D., P.A.

405 ST. HWY 121 BYPASS, BLDG A, STE 150, LEWISVILLE TX 75067
(469) 312-1130 FAX (972) 459-7221

HIPAA PRIVACY ACT INFORMATION FORM

Please check one of the boxes below for release of medical information:

Release information only to me: YES NO

Release information to my spouse: YES NO

Spouse's Full Name: _____

Release information to other: YES NO

Full Name: _____ Phone #: _____

Would you like for us to leave medical information on your voicemail?

YES NO Phone #: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Deborah T. Combs Cantrell, M.D., P.A. reserves the right to modify the privacy practices outlined in the notice.
I have received a copy of the Notice of Privacy Practices for Deborah T. Combs Cantrell, M.D., P.A.

_____ _____

Name of Patient (print) Signature of Patient/Patient Guardian

_____

Date

Deborah T. Combs Cantrell, M.D., P.A.
Financial and Office Policies

Patient Name: _____ **DOB:** _____

Payment:
Payment is due at the time of service. If you have insurance, your co-pay and/or deductible along with any co-insurance amount due will be collected prior to you seeing the physician. We accept Visa, Mastercard, American Express, Discover, debit cards, cash and checks. We will accept your check with a valid driver's license. Please present your driver's license along with your check.

Initials _____

Insurance:
As one of your insurance company preferred providers, we require you to first meet your copay, deductible and/or any part that your insurance does not pay, at the time of service. Most misunderstandings about insurance can be avoided if you understand what your policy provides. If your insurance company chooses not to pay Deborah T. Combs Cantrell, M.D., P.A. for whatever reason or they choose to delay payment, YOU will be responsible for payment. If payment is not received within 90 days from your insurance company, you will become responsible for the outstanding balance. Payment is expected at the time of service. Our office will assist you as our patient in filing your claims that we are contracted with and after obtaining all insurance information needed from you. However, the stated policies regarding payment must be implemented because insurance companies have become more cavalier in the prompt processing of claims to physician's offices. We ARE NOT responsible for your insurance or YOUR bill.

Initials _____

Returned Checks:
There is a $30.00 charge for all returned checks. If a check is filed with the DA's office for collection, all fees incurred in the filing will be your responsibility as well. After a check has been returned twice for NSF, payments to our office will be on a

Initials _____

24 Hour Cancellation Notice:
Our office requires patients to notify us 24 hours in advance of their scheduled appointment for any cancellation or need to reschedule. Failure to do so or failure to show for your scheduled appointment will result in a cancellation or no show fee. New patient fee is $100.00, established patient fee is $50.00

Initials _____

Insurance Carriers Requiring Referral Numbers (HMO, POS, EPO):
If your insurance carrier requires you to have a referral number prior to your seeing a specialist, our office must be IN receipt of the referral number **BEFORE** your arrival. If we do not have it upon sign-in, your appointment will be rescheduled to a later date and time or full payment must be made prior to the office visit.

Initials _____

PRESCRIPTIONS:
Our office requires a 48-hour notice when requesting any medication refills. ***No Refills are approved after hours***

Initials _____

Out Patient Procedures Ordered:
Patients are financially responsible for any outpatient procedure(s) ordered by their physician. Our office will assist in obtaining proper authorization for the procedure prior to the date and time. You, the insured, are ultimately responsible for what your coverage requires and we suggest that you contact insurance carrier to verify your benefits and preauthorization requirements prior to having the procedure done. Our office will not be responsible for your charges.

Initials _____

_____

Patient's Signature & Date