

TEXAS NEUROLOGY

6301 GASTON AVE, SUITE 100, WEST TOWER, DALLAS, TEXAS 75214
PHONE 214-827-3610 FAX 214-821-4017

PLEASE COMPLETE THE ENCLOSED INFORMATION PRIOR TO YOUR INITIAL CONSULTATION WITH **DR. EL-FEKY**. A MEDICATION LOG IS INCLUDED FOR YOU TO COMPLETE AND MAINTAIN FOR EACH FOLLOW-UP VISIT. PLEASE BRING IT WITH YOU TO EVERY VISIT. WE REQUIRE THAT YOU BRING MEDICAL RECORDS FROM YOUR REFERRING PHYSICIAN, ALONG WITH ANY RECENT DIAGNOSTIC STUDIES. PLEASE FEEL FREE TO CONTACT OUR SCHEDULING DEPARTMENT WITH ANY QUESTIONS RELATING TO THE INFORMATION CONTAINED WITHIN THIS PACKET.

IT IS VERY IMPORTANT THAT YOU BRING YOUR INSURANCE CARD(S) AND ID ON THE DAY OF YOUR APPOINTMENT. PLEASE REMEMBER THAT IT IS YOUR RESPONSIBILITY TO OBTAIN A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN (IF YOUR INSURANCE REQUIRES IT).

AS A COURTESY REMINDER, WE WILL CALL YOU TWO (2) DAYS PRIOR TO YOUR SCHEDULED APPOINTMENT TO CONFIRM YOUR APPOINTMENT DATE AND TIME. IF FOR ANY REASON YOU CANNOT MAKE YOUR APPOINTMENT, PLEASE CALL AT LEAST 24 HOURS IN ADVANCE TO CANCEL OR RESCHEDULE. IT IS THE POLICY OF TEXAS NEUROLOGY THAT ALL PATIENTS WHO DO NOT PROVIDE 24 HOURS ADVANCED NOTIFICATION OF CANCELLATION WILL BE SUBJECT TO THE FOLLOWING FEES:

NEW PATIENTS/CONSULTATIONS - \$50

TESTING - \$50

FOLLOW UP APPOINTMENTS - \$25

PLEASE CHECK IN ON THE 1ST FLOOR, SUITE 100.
THANK YOU AND WE LOOK FORWARD TO SEEING YOU!

APPT DATE: _____ APPT TIME: _____ PHYSICIAN: W. EL-FEKY, M.D.

PATIENT REGISTRATION



Physician you are seeing today: _____ Today's Date: _____

NAME: _____ DATE OF BIRTH: _____
First MI Last

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Business Phone (_____) _____ Age _____

Sex _____ Marital Status _____ SS# _____ - _____ - _____ Email: _____

Ethnicity: Caucasian African American Asian/Pacific Islander Hispanic Other

Referring Doctor _____ Phone (_____) _____

Primary Care Doctor _____ Phone (_____) _____

Pharmacy Information _____ Phone (_____) _____

EMPLOYER: _____ OCCUPATION: _____

Address _____ City _____ State _____ Zip _____

Emergency Contact: _____ Phone Number (_____) _____ Relationship _____

Is there anyone you would like to authorize us to speak with concerning your medical information? We will speak only to you if none is selected.

None Name _____ Contact Number (_____) _____ Relationship _____

Is it ok to leave personal/medical information on your voicemail? Home Mobile Work None

Please provide a current picture id and insurance card(s) to the receptionist at time of arrival. You are required to provide your active insurance card or payment will be required at time services are rendered. Thank you for your cooperation.

For Office Use Only:
Insurance Card Received: _____
Staff Initials

INSURANCE AUTHORIZATION: I HEREBY AUTHORIZE TEXAS NEUROLOGY TO FURNISH MEDICAL RECORDS &/OR TEST RESULTS INCLUDING HIV STATUS, VIA FAX OR MAIL, TO MY REFERRING DOCTOR, INSURANCE COMPANIES AND TO THE DOCTOR TO WHOM I AM REFERRED CONCERNING MY ILLNESS AND TREATMENT. I WILL NOT HOLD TEXAS NEUROLOGY OR ITS EMPLOYEES RESPONSIBLE FOR ANY MISDIRECTED RECORDS OR CORRESPONDENCE. I UNDERSTAND THAT ALL PAYMENTS &/OR COPAYMENTS INCLUDING NON-COVERED SERVICES ARE DUE AT THE TIME OF SERVICE, UNLESS I AM COVERED UNDER A WORKERS' COMPENSATION CLAIM. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO TEXAS NEUROLOGY FOR ALL SERVICES RENDERED.

BY SIGNING THIS FORM I CONSENT TO TREATMENT NECESSARY FOR THE CARE OF THE PATIENT INDICATED ON THIS FORM.

Signature _____

Date _____

TEXAS NEUROLOGY

6301 GASTON AVE, SUITE 100, WEST TOWER, DALLAS, TEXAS 75214
PHONE 214-827-3610 FAX 214-821-4017

Date: _____

Patient's Name: _____

Date of Birth: _____

Street Address: _____

Age: _____

City, State, Zip: _____

Home Phone: _____

E-Mail: _____

Work Phone: _____

Referring Physician: _____

Office Phone: _____

Address: _____

Fax: _____

Unless you object, a copy of the clinic notes will be sent to the referring physician. Please check here (____) if you **DO NOT** want that. Please use the back of this page to list any physicians who should receive copies.

Other Neurologists that you have seen: _____

CHIEF COMPLAINT: Please write a concise statement describing the neurological condition, symptom, or diagnosis (the reason for neurological consultation).

HISTORY OF PRESENT ILLNESS: Please write a brief chronological description of your neurological condition (the above chief complaint).

PAST MEDICAL HISTORY: Please list any previous and/or current illnesses and treatments (example: diabetes, high blood pressure, cancer, TB) **Please include any prior hospitalizations and dates:**

Reviewed by Provider: _____

MEDICATION LOG: Attach copy of Current Medication Log at Registration.

LIST ANY MEDICATIONS TO WHICH YOU ARE ALLERGIC:

LIST ALL OTHER PILLS, SYRUPS, TONICS, VITAMINS, HERBS, ETC.:

SURGICAL, PREGNANCY, AND INJURY HISTORY: Provide date of operation, injury, or pregnancy:

Surgeries: _____

Injuries: _____

FAMILY HISTORY: List any illnesses in your family, including parents, grandparents, siblings, or children, especially those that are similar to your current problem.

SOCIAL HISTORY AND OTHER INFORMATION:

Which hand do you write with? <input type="checkbox"/> Left <input type="checkbox"/> Right	Do you smoke cigarettes? (or use any form of tobacco) <input type="checkbox"/> Never <input type="checkbox"/> Quit <input type="checkbox"/> Yes
Marital Status _____	Do you drink beer, wine, alcohol? <input type="checkbox"/> Never <input type="checkbox"/> Quit <input type="checkbox"/> Yes <input type="checkbox"/> Daily
What is/was your occupation? _____	Have you ever been exposed to HIV? <input type="checkbox"/> Never <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know
How much do you weigh? _____	
How tall are you? _____	

Reviewed by Provider: _____

SYMPTOM INVENTORY: Please mark a check in the appropriate boxes below to indicate whether you have had symptoms within the past year. If you check any item, please briefly describe it in the appropriate blank.

REVIEW OF SYSTEMS - GENERAL		
Cardiac (Heart) <input type="checkbox"/> Yes <input type="checkbox"/> No	Depression <input type="checkbox"/> Yes <input type="checkbox"/> No	Dermatologic (Skin) <input type="checkbox"/> Yes <input type="checkbox"/> No
Ear / Nose / Throat <input type="checkbox"/> Yes <input type="checkbox"/> No	Fatigue <input type="checkbox"/> Yes <input type="checkbox"/> No	Fevers <input type="checkbox"/> Yes <input type="checkbox"/> No
Genitourinary(Bladder) <input type="checkbox"/> Yes <input type="checkbox"/> No	GI(Stomach/Liver) <input type="checkbox"/> Yes <input type="checkbox"/> No	Hematologic (Blood) <input type="checkbox"/> Yes <input type="checkbox"/> No
Musculoskeletal <input type="checkbox"/> Yes <input type="checkbox"/> No	Peripheral Vascular (Blood Vessels) <input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory (Lung) <input type="checkbox"/> Yes <input type="checkbox"/> No
Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No	Night Sweats <input type="checkbox"/> Yes <input type="checkbox"/> No	Other <input type="checkbox"/> Yes <input type="checkbox"/> No

REVIEW OF SYSTEMS - NEUROLOGIC		
Headache <input type="checkbox"/> Yes <input type="checkbox"/> No	Blurred Vision <input type="checkbox"/> Yes <input type="checkbox"/> No	Weakness – Arms <input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No	Double Vision <input type="checkbox"/> Yes <input type="checkbox"/> No	Weakness – Legs <input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting <input type="checkbox"/> Yes <input type="checkbox"/> No	Blindness <input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness – Arms <input type="checkbox"/> Yes <input type="checkbox"/> No
Confusion <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Visual Changes <input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness – Legs <input type="checkbox"/> Yes <input type="checkbox"/> No
Concentration <input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Chewing <input type="checkbox"/> Yes <input type="checkbox"/> No	Tingling/Pain <input type="checkbox"/> Yes <input type="checkbox"/> No
Memory <input type="checkbox"/> Yes <input type="checkbox"/> No	Facial Numbness/Tingling <input type="checkbox"/> Yes <input type="checkbox"/> No	Stiffness <input type="checkbox"/> Yes <input type="checkbox"/> No
Lethargy <input type="checkbox"/> Yes <input type="checkbox"/> No	Drooling <input type="checkbox"/> Yes <input type="checkbox"/> No	Clumsiness <input type="checkbox"/> Yes <input type="checkbox"/> No
Personality Change <input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Tasting <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain <input type="checkbox"/> Yes <input type="checkbox"/> No
Hallucinations <input type="checkbox"/> Yes <input type="checkbox"/> No	Ringing in ears <input type="checkbox"/> Yes <input type="checkbox"/> No	Poor Balance <input type="checkbox"/> Yes <input type="checkbox"/> No
Speech Difficulty <input type="checkbox"/> Yes <input type="checkbox"/> No	Trouble Sleeping <input type="checkbox"/> Yes <input type="checkbox"/> No	Poor Coordination <input type="checkbox"/> Yes <input type="checkbox"/> No
Spells <input type="checkbox"/> Yes <input type="checkbox"/> No	Decreased Hearing – R / L <input type="checkbox"/> Yes <input type="checkbox"/> No	Trouble Walking <input type="checkbox"/> Yes <input type="checkbox"/> No
Nausea <input type="checkbox"/> Yes <input type="checkbox"/> No	Trouble Swallowing <input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence-Bladder <input type="checkbox"/> Yes <input type="checkbox"/> No
Vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No	Hoarseness <input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence-Bowel <input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble with Smell <input type="checkbox"/> Yes <input type="checkbox"/> No	Choking <input type="checkbox"/> Yes <input type="checkbox"/> No	Other <input type="checkbox"/> Yes <input type="checkbox"/> No
Other <input type="checkbox"/> Yes <input type="checkbox"/> No	Other <input type="checkbox"/> Yes <input type="checkbox"/> No	Other <input type="checkbox"/> Yes <input type="checkbox"/> No

Reviewed by Provider: _____

HAVE YOU HAD ANY OF THESE TESTS?

YES	NO	TEST	DATE	WHERE DONE	RESULT
<input type="checkbox"/>	<input type="checkbox"/>	MRI	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/>	<input type="checkbox"/>	CT Scan	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/>	<input type="checkbox"/>	EEG (Brain Wave Recording)	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/>	<input type="checkbox"/>	EP (Evoked Potential) Study	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/>	<input type="checkbox"/>	EMG and Nerve Conductions	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Arteriogram	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/>	<input type="checkbox"/>	Carotid Doppler	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/>	<input type="checkbox"/>	Echocardiogram	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/>	<input type="checkbox"/>	LP (Spinal Tap)	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/>	<input type="checkbox"/>	Myelogram	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/>	<input type="checkbox"/>	Blood Tests (Specify)	_____	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

IS THERE ANYTHING ELSE YOU WOULD LIKE TO TELL OUR OFFICE?

FOR PROVIDER USE ONLY	
DATE: _____	SIGNATURE: _____

**TEXAS NEUROLOGY
SLEEP DISORDERS CENTER**

NAME: _____

DATE: _____

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling “just tired”? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation.

0=would never doze

1=slight chance of dozing

2=moderate chance of dozing

3=high chance of dozing

<u>Situation</u>	<u>Chance of Dozing</u>
Sitting and reading	_____
Watching television	_____
Sitting inactive in a public place (movie theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking quietly to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
	TOTAL _____

I understand that I should not drive when sleepy or drowsy.

Patient Signature

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TO TEXAS NEUROLOGY FROM THE NORTH

Highway 75 (Central Expressway)

1. Travel south on Highway 75 (North Central Expressway)
2. Exit Mockingbird and turn left (eastbound)
3. Take Mockingbird to Skillman, turn right on Skillman
4. Take Skillman to Oram turn left on Oram, go to 1st stop sign
5. Turn right into parking lot after stop sign.

North Dallas Tollway

1. Take the tollway south, through the toll plazas and continue to downtown.
2. Take Pearl St. exit (left) and follow Pearl St. through downtown for 6 traffic lights until you reach Pacific. Turn left (under Central Expressway).
3. Pacific Street will change into Gaston Ave. After you go under the expressway.
4. Continue down Gaston approximately 2.5 miles to Paulus Ave.
5. Turn left on Paulus, go through one light (La Vista Dr.) turn right into parking lot.

Interstate 35 Stemmons Freeway

1. Travel South on Interstate 35 to the downtown interchange.
2. Follow signs for I-30 East Texarkana. Proceed to merge right.
3. Continue east until you come to the Munger Blvd. exit.
4. Exit Munger Blvd. and turn left.
5. Take Munger to Gaston Ave, turn right onto Gaston.
6. Take Gaston to Paulus, turn left. Go through one light (LaVista Dr.) turn right into parking lot.

TO TEXAS NEUROLOGY FROM THE WEST

(I-30) Arlington, Grand Prairie, Mid-Cities and Fort Worth

1. Take I-30 East Texarkana.
2. Take the Munger Blvd. exit and turn left.
3. Take Munger Blvd to Gaston Ave. and turn right onto Gaston.
4. Take Gaston to Paulus Ave. and turn left on Paulus.
5. Go through one light (LaVista Dr.), turn right into parking lot.

Highway 114 (DFW Airport Using the North Exit)

1. Travel East down Hwy 114 to the intersection of 183.
2. Take 183 east, then go South on Interstate 35.
3. Proceed onto 75/45 following the Houston signs until you reach 75 North and 75 South directional signs. Exit onto 75 North.
4. Take 75 North to the Haskell exit, turn right onto Haskell.
5. Follow Haskell to Gaston Ave. turn left on Gaston.
Take this approx. 2 miles to Paulus Ave.
6. Turn left onto Paulus.
7. Go through one light (LaVista Dr.), turn right into parking lot.

TO TEXAS NEUROLOGY FROM THE SOUTH

Interstate 35

1. Take 35 North to the downtown interchange and exit I-30 East Texarkana. Proceed to merge right (eastbound).
2. Continue east, exit Munger Blvd. and turn left.
3. Take Munger to Gaston Ave. and turn right.
4. Take Gaston to Paulus Ave. and turn left.
5. Go through one light (LaVista Dr.), turn right into parking lot.

Interstate 20

1. Take I-20 East to 67 North.
2. Take 35 North to the downtown interchange and exit I-30 East Texarkana. Proceed eastbound
3. Exit Munger Blvd., turn left.
4. Take Munger Blvd. to Gaston Ave. Turn right onto Gaston.
5. Take Gaston to Paulus Ave., turn left.
6. Go through one light (LaVista Dr.), turn right into parking lot.

TO TEXAS NEUROLOGY FROM THE EAST

(I-30 East / US 80 East)

1. Take I-30 West, exit Munger Blvd. and turn right.
2. Take Munger to Gaston Ave. turn right onto Gaston.
3. Take Gaston to Paulus Ave. turn left onto Paulus.
4. Go through one light (La Vista), turn right into parking lot.

(Street Directions)

1. Take Buckner Blvd. north, turn left onto Garland Rd.
2. Follow to Gaston Ave. (merge right).
3. Continue on Gaston, pass the Abrams Rd. intersection turn right onto Paulus Ave.
4. Go through one light (LaVista Dr.), turn right into parking lot.

To Texas Neurology from 635 West /LBJ Freeway

1. Take 635 West, exit Abrams Road, turn right.
2. Take Abrams to Gaston Ave., turn right.
3. Take Gaston to Paulus Ave., turn right.
4. Go through one light (LaVista Dr.), turn right into parking lot.

To Texas Neurology from 635 East/LBJ Freeway

1. Take 635 East, exit Abrams Road, turn left.
2. Take Abrams to Gaston Ave, turn right.
3. Take Gaston to Paulus Ave., turn right.
4. Go through one light (LaVista Dr.), turn right into parking lot.

Interstate 45 (Ennis)

1. Travel north following Sherman signs.
2. Take I-30 East Texarkana.
3. Exit Munger Blvd and turn left.
4. Take Munger to Gaston Ave and turn right onto Gaston.
5. Take Gaston to Paulus turn left on Paulus.
6. Go through one light (LaVista Dr.), turn right into parking lot.

Access to parking is off Paulus Avenue and Alderson Street next to the Wells Fargo Bank Building.
Texas Neurology is located in the WEST TOWER on the 1st FLOOR.