

Atlanta Vascular Specialists

775 Poplar Road, Suite 260, Newnan, GA 30265
PH 404-524-0095 Fax 404-658-9558

Eric D. Wellons, M.D.

James M. Combs, M.D.

John D. Dooley, M.D.

Dear Mr./Mrs. _____

You have an appointment on _____ @ _____
with Dr. _____

At our _____ office (directions enclosed).

Please arrive 15 minutes early for your appointment to allow for check in time.

Enclosed you will find the forms you need to complete for your new patient evaluation. We are sending this to you prior to your appointment to give you time to consider and prepare your answers accurately, as documentation of your medical conditions are a very important part in allowing us to give you the best care possible. Please fill out all of the paperwork and bring it with you to your appointment, along with your picture ID and insurance cards. **DO NOT MAIL IT BACK TO US.** If your paperwork is brought in incomplete, you forfeit your appointment time and will be rescheduled to the next available appointment.

If your insurance is an HMO policy, it is your responsibility to obtain a referral from your primary care doctor. If you do not have a referral at the time of your appointment, you forfeit your appointment time and may be rescheduled.

When you arrive in our office, we will need to know about any medications you are currently taking. Please bring a list for us to make a copy for our records. If you are allergic to any medications, we need to know what the drug is and what kind of reaction you experienced.

If you have had any testing done prior to your visit such as ultrasounds or CT scans, please bring a copy of the results with you or ask your physician to fax the results to our office at 404-658-9558.

Help Us Help You – Our goal is to provide you with the best possible care for your vascular health. By taking a few minutes at home to fill out these forms you will expedite your visit.

If you have any questions or concerns, prior to your visit, please don't hesitate to contact our office.

Sincerely,

Your Partners in Healthcare
Atlanta Vascular Specialists

Atlanta Vascular Specialists

Phone: 404) 524-0095 Fax: 404)658-9558

Eric D. Wellons, M.D. - James M. Combs, M.D. - John D. Dooley, M.D.

Newnan Office

775 Poplar Road, Suite 260—Newnan, Ga. 30265

***Traveling South from Downtown Atlanta:** From Downtown Atlanta, take I-75/I-85 South. Continue at exit 242 to I-85 South, past Hartsfield-Jackson Airport. Take Exit 47 (Ga-34, Newnan/Shenandoah). Turn Right onto Bullsboro Drive/GA-34 West. Go approximately .7 miles and turn Left onto Newnan Crossing Bypass. Go 2.4 miles and turn Left onto Poplar Road. Take the 2nd entrance into the Piedmont Medical Plaza on the Right. Continue to the Medical Office Building ahead. We are on the 2nd floor, Suite 260.

***Traveling North from Columbus/LaGrange:** Travel North on I-85. Take Exit 47 (Ga-34, Newnan/Shenandoah). Turn Left onto Bullsboro Drive/GA-34 West. Go approximately .7 miles and turn Left onto Newnan Crossing Bypass. Go 2.4 miles and turn Left onto Poplar Road. Take the 2nd entrance into the Piedmont Medical Plaza on the Right. Continue to the Medical Office Building ahead. We are on the 2nd floor, Suite 260.

Fayetteville Office

1233 West Highway 54, Suite 210—Fayetteville, Ga. 30214

***Traveling South from Downtown Atlanta:** From downtown Atlanta, take I-75/I-85 South. Continue at exit 242 to I-85 South, past Hartsfield-Jackson International Airport. Take Exit 61 (Peachtree City/Fairburn). Turn left onto GA Hwy 74/Senoia Road. Just within the city limits of Tyrone, take the second left onto Sandy Creek Road. Follow Sandy Creek Road for approximately 4.7 miles and turn right to stay on Sandy Creek Road. Go 0.9 miles and turn left to stay on Sandy Creek Road. Go 0.8 miles and turn right to Ga. 54/West Lanier Ave. Take your first right into the Medical Office Building driveway (just before the entrance to the Piedmont Fayette Hospital). Take the elevator to the 2nd floor, suite 210.

***Traveling from South of Atlanta Coming North on I-75 :** Travel North on I-75. Take Exit 237A (Riverdale Road Exit). This exit becomes State Road GA Hwy 85. Travel South on State Road GA Hwy 85 for approximately twelve (12) miles to Fayetteville. At the courthouse square in downtown Fayetteville, turn right at the light on GA Hwy 54 / Lanier Avenue toward Peachtree City. Piedmont Fayette Hospital will be three (3) miles on your right at the traffic light. Turn right into the Medical Office Building driveway just BEFORE the hospital entrance. Take the elevator to the 2nd floor, suite 210.

Atlanta Vascular Specialists – Patient Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ____/____/____ Age: _____ Social Security No.: _____ - _____ - _____

Marital Status: M S D W Race: Asian Black White Other Gender: M F

Primary Language: _____ Ethnic Group: Hispanic/Latino Not Hispanic/Latino

Address: _____ Apt # _____ City: _____

State: _____ Zip: _____ Home Ph. _____ Cell Ph. _____

Office Ph. _____ E-Mail: _____

Preferred Method of Contact: Home Phone Cell Phone Office Phone E-Mail

EMERGENCY CONTACT: please provide the nearest relative NOT living with you

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

INSURANCE INFORMATION:

Medicare #: _____ Medicaid #: _____

Primary Insurance Co. Name: _____

Policy/ID #: _____ Group #: _____

Policy Holder: _____ S.S.# _____ - _____ - _____

Policy Holder-Date of Birth: ____/____/____ Relationship to patient: _____

Secondary Insurance Co. Name: _____

Policy/ID #: _____ Group #: _____

Policy Holder: _____ S.S.#: _____ - _____ - _____

Policy Holder-Date of Birth: ____/____/____ Relationship to patient: _____

PHYSICIANS:

Referring Physician: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Cardiologist: _____ Phone #: _____

AUTHORIZATION and ASSIGNMENT: I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf, I assign the benefits payable to which I am entitled including private insurance and other health plans to Atlanta Vascular Specialists (AVS). This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize the practice to appeal any incorrect insurance payment.

Signature/Responsible Party: _____ Date: _____

ATLANTA VASCULAR SPECIALISTS • VEIN SPECIALISTS OF GEORGIA

DR. ERIC D. WELLONS

DR. JAMES M. COMBS

Dr. JOHN D. DOOLEY

775 Poplar Road, Suite 260 Newnan, GA 30265

1233 West Highway 54, Suite 210 Fayetteville, GA 30214

RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If so, you may obtain a revised copy by contacting Carol Daigle, RN or Connie Dillard, Practice Administrator. By signing below, you acknowledge that you have received a copy of our Notice of Privacy Policies on the date indicated below.

Print Name of Patient: _____

Patient DOB: ____/____/____

RELEASE OF INFORMATION

I authorize the release of information including diagnostic, records; examination rendered to me and claims information. This information may be released to:

Spouse _____

Child _____

Child _____

Child _____

Caregiver/Friend _____

The Release of Information will remain in effect until terminated by me in writing.

MESSAGES

Please call: my home

my work

my cell

Number _____

Number _____

Number _____

If unable to reach me: (Choose One)

you may leave a detailed message

please leave a message asking me to return your call

The best time to reach me is (day) _____

between (time) _____

Signed: _____

Date: _____

Witness: _____

Date: _____

Personal Medical History (Please mark the year you were diagnosed in the box provided)

<u>Condition</u>	<u>Year</u>	<u>Condition</u>	<u>Year</u>
<u>Cardiovascular</u>		<u>Renal/ Genitourinary</u>	
Abdominal Aortic Aneurysm		Acute Renal Failure	Headaches/ Migraines
Aneurysm, other		Bladder Infection	Tension Headaches
Angina		Urinary Tract Infection	Meningitis
Arrhythmia		Chronic renal Failure	Mental Retardation
Arterial Thrombosis		Dialysis	Multiple Sclerosis
Carotid Artery Stenosis		Enlarged Prostate	Muscular Dystrophy
Congestive Heart Failure		Erectile Dysfunction	Myasthenia Gravis
Coronary Artery Disease		Kidney Infection	Parkinson's Disease
Deep Vein Thrombosis		Urinary Incontinence	Peripheral Sensory Neuropathy
Heart Disease		Other _____	Seizure Disorder
High Cholesterol		<u>Musculoskeletal</u>	Stroke
High Blood Pressure		Arthritis	Transient Ischemic Attack (TIA)
Heart Attack		Chronic Pain	<u>Cancer</u>
Irregular Heartbeat		Fibromyalgia	Bone Cancer
PAD/ Atherosclerosis		Fracture	Brain Tumor
Superficial Phlebitis		Gout	Breast Cancer
Varicose Veins		Osteoarthritis	Colon Cancer
Venous Insufficiency		Osteoporosis	Hepatic Carcinoma (Liver)
Lymphedema		Rheumatoid Arthritis	Leukemia
<u>Pulmonary</u>		Lupus	Lung Cancer
Asthma		<u>Endocrine</u>	Lymphoma
Chronic Bronchitis		Addison's Disease	Melanoma
COPD		Diabetes Insulin Dependent	Pancreatic
Cystic Fibrosis		Diabetes Non Insulin Dependent	Prostate
Emphysema		Hepatitis	Renal (Kidney)
Lung Infection		Hyperthyroidism	Skin
Pneumonia		Jaundice	Testicular
Pulmonary Embolism		Enlarged Thyroid	Thyroid
Pulmonary Hypertension		Other _____	Other _____
Sleep Apnea		<u>Hematology</u>	Allergies
Tuberculosis		Bleeding Disorder	Chicken Pox
<u>Gastrointestinal</u>		Hemolytic Anemia	HIV
Cirrhosis of Liver		Iron Deficiency Anemia	Immunodeficiency
Colitis		Pernicious Anemia	Infectious Disease
Colon Polyps		_____ Anemia	<u>Other</u>
Diverticulitis		Other _____	Cataract
Hepatitis		<u>Neurological</u>	Glaucoma
Hemorrhoids		Alzheimer's	Medication Noncompliance
Indigestion/ Heartburn		Attention Deficit Disorder	Obesity
Irritable Bowel Syndrome		Attention Deficit Hyperactivity	Ovarian Cysts
Pancreatitis		Cerebral Palsy	Pregnancy (how many?)
Reflux		Dementia	<u>Conditions Not Listed</u>
Stomach Ulcer Disease		Depression	
Other _____		Downs Syndrome	

Surgical History

- No surgical history
- Previous anesthesia problems
- Previous blood transfusion

Please mark the year next to the surgical procedure

<u>Surgery</u>	<u>Year</u>	<u>Surgery</u>	<u>Year</u>	<u>Surgery</u>	<u>Year</u>
Breast Surgery		Amputation		Fistulogram	
Bleeding Problems		Heart Cath		Angioplasty	
C-Section		Heart Bypass Surgery		Arteriogram	
Cataract Removal		Heart Stent		Bypass Graft (Extremity)	
Appendectomy		Pacemaker		Carotid Surgery	
Cosmetic Surgery		Defibrillator Placed		ABD Aneurysm Repair	
Hysterectomy		Orthoscopic Surgery		IVC Filter Placed	
Injury Related		Dialysis Graft or Fistula		Perma-cath Placement	
Hemorrhoidectomy		Spider Vein Treatment		Embolectomy	
Tonsils Removed		Varicose Vein Surgery		Stent Placement (renal)	
Tubal Ligation		De-clotting Procedure		Stent Placement (legs)	
Gall Bladder Surgery		Hernia Repair			

Family History

Mother (M) Father (F) Brother (B) Sister (S) Aunt (A) Uncle (U) Maternal Grandmother (Mat-M) Paternal Grandmother (Pat-M)
 Maternal Grandfather (Mat-F) Paternal Grandfather (Pat-F)

Please mark in the appropriate block which family member has/had the following medical conditions:

<u>Condition</u>	<u>Family Member</u>	<u>Comments</u>	<u>Condition</u>	<u>Family Member</u>	<u>Comments</u>
Carotid Stenosis			Aneurysm		
Stroke/ TIA			Diabetes		
Cancer			PVD		
Varicose/ Spider Veins			Renal Failure		
Venous Disease			Blood Clot		
High Blood Pressure			High Cholesterol		
Heart Disease			Bleeding Disorder		
Lung Problems			COPD		
Hepatitis B/C			Parkinson's Disease		
Multiple Sclerosis			Alzheimer's		
Hyperthyroidism			Hypothyroidism		

Social History

Information obtained from: patient spouse parent significant other sibling child caretaker other

Marital Status: married divorced single widowed **Number of children:** _____

Other living arrangements: assisted living nursing home other: _____

Do you exercise? Yes No

Alcohol Use: denies use yes-social yes-daily

Tobacco Use: never previously stopped packs/day _____ # of years _____

currently smoking packs/day _____ # of years _____

Substance Use: never yes type: _____ frequency: _____

Have you ever worn support hose? yes no if so, how long? _____

Review of Systems (to be completed by patient)

General

- Weight Gain
- Weight Loss
- Fever
- Fatigue
- None apply

Eyes

- Cataracts
- Glasses/contacts
- Impaired
- Redness
- Vision changes
- None apply

Ear/Nose/Throat

- Bad breath
- Ear disease
- Ear injury
- Hearing impairment
- Mouth sores
- Nose bleeds
- Sinus problems
- Sneezing
- Sore throat
- Voice changes
- None apply

Genitourinary

- Burning
- Sexual activity (impotence)
- Incontinence
- Urgency
- Blood in urine (hematuria)
- Renal failure
- None apply

Allergic/Immunity

- Allergic reaction
- Seasonal allergies
- None apply

Psychiatric

- Depression
- Memory changes
- Sleep disturbances
- Anxiety
- None apply

Hematol/Lymphatic

- History of blood transfusions
- Slow to heal
- Enlarged glands
- Anemia
- Excessive bleeding
- Easy bruising
- None apply

Gastrointestinal

- Abdominal pain/swelling
- Appetite changes
- Bloody or black stools
- Bowel movement changes
- Constipation
- Diarrhea
- Acid reflux
- Heartburn/indigestion
- Nausea
- Vomiting
- Rectal swelling/bleeding
- Dysphasia
- Bloating
- Trouble swallowing
- Vomiting blood
- None apply

Cardio Respiratory

- Chest pain
- Difficult breathing
- Palpitations/irregular rhythm
- Shortness of breath
- Swelling of feet/ankles
- Heart murmur
- Sleep disturbances
- High blood pressure
- None apply

Skin

- Scars
- Varicose veins
- Open wounds
- Discoloration
- Dry skin
- Thick toenails
- Drainage
- Hair/nail changes
- Fungal nail infection
- Mole changes
- Rashes
- Redness
- Lumps
- None apply

Extremities

- Amputations
- Bone/joint pain or swelling
- Burning sensations- feet/legs
- Cold sensations in the feet
- Cold sensations in the hands
- Difficulty walking
- Numbness in arms
- Numbness in legs
- Pain in leg/calf when walking
- Pain in legs at night
- Swelling of legs/feet
- Ulcers on arms/hands
- Ulcers on legs/feet
- Varicose veins
- Spider veins
- Weakness in arms/legs
- None apply

Neurological

- Fainting/loss of consciousness
- Temporary loss of vision
- Weakness in arms/legs
- Speech problems
- Numbness
- Dizziness
- Headaches
- Unsteadiness
- Tremors
- None apply

Musculoskeletal

- Back pain
- Muscle cramps
- Muscle weakness
- Arthritis
- Hip pain
- Shoulder pain
- Knee Pain
- None apply

Endocrine/Neck

- Hypothyroidism
- Hyperthyroidism
- Enlarged thyroid
- Enlarged glands
- Excessive thirst
- Hot flashes
- Intolerance to hot/cold
- Hair loss
- None apply

STOP HERE! PLEASE DO NOT FILL OUT BEYOND THIS POINT
Physical Exam

Name: _____ Date: ____/____/____

BP: ____/____ L-R Temp: _____ Pulse: _____ Resp: _____ HT: ____/____ WT: _____

CC: _____

Ulcer R L **Location:** Ankle Calf Thigh Mid Foot/Heel Foot or Toe: 1st digit 2nd digit 3rd digit 4th digit 5th digit

Size: _____ **Depth:** Skin Fat Muscle Bone

Dominant Hand: Right Left **Appearance:** well developed well nourished obese malnourished elderly thin

Grooming: well groomed disheveled unkempt multiple tattoos malodorous

Distress: none ILL appearing in pain lethargic appearing tired tearful toxic appearing

Eyes: Glasses: Y Drive only read only N **Contacts:** Y N **Blind:** R L normal lids lid edema redness PEERLA

Hearing: normal ABN AID Right ear Left ear both ear disease ear injury **Nose:** sinus tenderness normal

discolored on oxygen spider veins nose bleeds

Mouth: **Dentures:** Yes upper partial No **Tonsils:** Yes No **Tooth Pain:** Yes No

Skin: clear dry pink/healthy discolored bruising spider veins VV ulcers pale

Nails: **Hands:** normal pitted ridged thick discolored **Feet:** normal pitted ridged thick discolored

Neck: **Bruit:** R L none **Masses:** Yes No **Supple:** Yes No **JVD:** normal abnormal

Respiration: clear breath sounds rubs wheezes normal abnormal

Heart: **Murmur:** Y N **Rate:** normal abnormal **Rhythm:** normal abnormal **Bruits:** Y N pacemaker/difib

Ambul/Musc: ambulatory normal gait shuffles slow stooped unsteady cane walker wheelchair PA-M

Abdomen: **Bowel sounds:** Y N **Masses:** Y N **Bruits:** Y N flat/rounded/hernia soft/tender/non tender/scars

Neurological: alert/oriented x3 confused trembling neuropathy hands feet none

Stroke: L side weakness R side weakness **Speech:** normal loud stutter slowed flat

Psych: normal mood depression anxious agitated flat argumentative litigious **Flu Vaccine:** Yes No

Tobacco Use: never used tobacco current amount/freq. _____ previously...how long _____ **Pneumonia Vaccine:** Yes No

<u>Pressures</u>	<u>Right</u>	<u>Left</u>	<u>Palpable pulse</u>	<u>Right</u>	<u>Left</u>
Doppler	_____	_____	PT	Y/N	Y/N
PT	_____	_____	DP	Y/N	Y/N
DP	_____	_____	Radial	Y/N	Y/N
Index	_____	_____	Graft/Fistula	Thrill	No Thrill
Index	_____	_____			

Smoking Counseling? Yes No

Physician Recommendations/Orders: _____