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

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

Eric D. Wellons, M.D. **James M. Combs, M.D.**

Piedmont Newnan Hospital 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.

Piedmont Fayette Hospital Office

1267 West Highway 54, Suite 5300—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. Turn right into Piedmont Fayette Hospital at the traffic light. Go around to the back of the hospital-West Entrance (this is also the outpatient surgery entrance). After entering, take the elevators on your RIGHT to the 5th floor. We are in suite 5300.

***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. Go around to the back of the hospital-West Entrance (this is also the outpatient surgery entrance). After entering, take the elevators on your RIGHT to the 5th floor. We are in suite 5300.

ATLANTA VASCULAR SPECIALISTS • VEIN SPECIALISTS OF GEORGIA
DR. ERIC D. WELLONS
775 Poplar Road, Suite 260 Newnan, GA 30263
DR. JAMES M. COMBS
1267 West Highway 54, Suite 5300 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:_____ Signature of Patient:_____

Patient DOB:_____ Patient ID/Account Number:_____ Date:_____/_____/_____

Print Name of Personal Representative:_____ Relationship:_____

Signature of Personal Representative:_____ Date:_____

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_____
[] Children_____
[] Other_____

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:
[] 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:_____

ATLANTA VASCULAR SPECIALISTS

Please tell us how you were referred to us:

_____NEWSPAPER

____FAYETTE CITIZEN ____HENRY COUNTY TIMES ____NEWNAN HERALD

_____MAGAZINE

_____LIFESTYLE _____FAYETTE WOMAN _____COWETA SHOPPER

_____INTERNET

____GOOGLE SEARCH

OTHER: _____

AVS Vein Screening

Eric Wellons, M.D. James Combs, M.D. Fayetteville Office Newnan Office

Date:_____

Patient:_____DOB:_____

Any history of vein problems in the family (if so, relationship of family member)_____

ALLERGIES: _____, _____, _____

MEDICATIONS: (please include any blood thinners)

_____ _____
_____ _____
_____ _____

SURGERIES _____, _____
_____, _____

MEDICAL HISTORY

High Blood Pressure	Y_____	N_____	
Heart Disease	Y_____	N_____	
Diabetes	Y_____	N_____	
High Cholesterol	Y_____	N_____	
Stroke	Y_____	N_____	
Blood Clot	Y_____	N_____	
Tobacco use	N_____	Currently_____	Previously_____

Your Symptoms:

	Left Leg	Right Leg	Ankle	Calf
Leg pain often from prolonged sitting or standing	_____	_____	_____	_____
Swelling	_____	_____	_____	_____
Tired, heavy feeling in leg	_____	_____	_____	_____
Varicose Veins	_____	_____	_____	_____
Spider Veins	_____	_____	_____	_____
Discoloration of skin	_____	_____	_____	_____
Open sores or ulcers on lower leg	_____	_____	_____	_____

How would you describe your pain? (CHECK ALL THAT APPLY)

ACHING_____ BURNING_____ CRAMPING_____

STABBING_____ ITCHING_____ TINGLING_____ NUMBNESS_____

When did your symptoms begin? Days_____Weeks_____

Months_____Years_____

How frequent are your symptoms? Hourly_____daily_____ weekly_____

DEGREE OF PAIN MEASURED FROM 1 (minimal) – 10 (worst)

___1___2___3___4___5___6___7___8___9___10

Have you ever had varicose vein bleeding? YES_____NO_____

Have you ever had leg ulcers ? YES_____ NO_____

Have you had previous vein treatment? YES_____ NO_____

If so, please list what kind of treatment and when: _____

_____

Have you ever tried conservative treatment? YES_____ NO_____

If so, please check below:

DESCRIBE:

Tried wearing SUPPORT HOSE YES_____ NO_____

*If yes, how long? _____

Tried FREQUENT ELEVATION YES_____ NO_____

Tried any MEDICATION (OVER THE COUNTER) YES_____ NO_____

Tried any PRESCRIPTION MEDICATION YES_____ NO_____

Tried WEIGHT REDUCTION YES_____ NO_____

Tried DAILY WALKING YES_____ NO_____

Tried to AVOID PROLONG SITTING/STANDING YES_____ NO_____

Tried LYING STILL YES_____ NO_____

DOES THIS CONDITION INTERFERE WITH DAILY LIVING? YES_____ NO_____

If yes, how many times a day? _____

What makes your condition worse:

Standing_____ Walking_____ Lifting_____Exertion_____

Bending Over_____Friction from Clothes_____ Sitting_____

Notes: _____

_____

_____

_____

_____

_____

_____

_____

_____

Dr. Signature:_____ Date:_____

Assistant: _____