Atlanta Vascular Specialists
775 Poplar Road, Suite 260, Newnan, GA 30265
PH 404-524-0095 Fax 404-659-9558

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

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 – 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
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:_____

New Patient Vascular Form

E. Wellons, M.D. James Combs, M.D. □Fayetteville Office □Newnan Office

Date:_____/_____/_____ Patient Name:_____ DOB:____/_____/____

SS#:_____-_____-_____ Age:_____ Referring physician_____

Primary Care Doctor_____ Cardiologist_____

Nephrologist:_____ **Pharmacy_____

Pharmacy phone #_____ Pharmacy address_____

Chief Complaint:_____

_____

History of Present Illness

Location of pain:_____ **Location of swelling**_____

Describe your type of pain: □ aching □ burning □ cramping □itching □stabbing □ tingling

What helps? □ hose □ rest/elevation □walking □ lying down □ OTC medications □ other_____ □ none

What causes? □ walking □ prolonged sitting □ standing □ other _____ □ none

Severity of pain:_____ (rate from 1-10) **Severity of swelling**:_____(rate from mild to severe)

How long has there been pain?_____ **swelling?**_____

How often do you have pain?_____ **swelling?**_____

What medications help?_____

Do you have any of these symptoms currently? □ dizziness □ slurred speech □ loss of balance □ weakness on one side or the other □ headaches □ loss of vision/vision changes □ facial drooping

Do you smoke? □ Yes □ No **Have you ever used tobacco?** □ Yes □ No

Have you had your pneumonia vaccine? □ Yes □ No **If not, why?**_____

Have you had a mammogram? □ Yes □ No **Year**_____ **Have you had a colorectal screening?** □ Yes □ No **Year**_____

Have you ever worn support hose? □ Yes □ No **if so, how long?** □ weeks □ months □ years

Dialysis Patients Only

Are you on dialysis? □ Yes □ No **When did you last dialyze?** _____

Do you currently have a Fistula or Graft? □ Yes □ No **if so** □ right □ left

Do you have a Perma Cath? □ Yes □ No **any pain?** _____(1-10) **swelling?** _____(mild to severe)

Current Medications

Drug	Dosage	Number of times per day

Do you have any drug allergies? _____

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

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

Surgery	Year	Surgery	Year	Surgery	Year
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		Abdominal Aneurysm	
Hysterectomy		Orthoscopic Surgery		IVC Filter	
Injury Related		Dialysis Graft or Fistula		Perma-cath Placement	
Hemorrhoidectomy		Spider Vein Treatment		Embolectomy	
Tonsils		Varicose Vein Surgery		Stent Placement (renal)	
Tubal Ligation		De-clotting Procedure		Stent Placement (legs)	
Gall Bladder					

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:

Condition	Family Member	Comments	Condition	Family Member	Comments
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

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

Hemalt/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 he 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: _____

_____

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

Grooming: □well groomed □disheveled □unkempt □multiple tattoos

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

Eyes: **Glasses**: □Yes □No **Contacts**: □Yes □No **Blind**: □R □L □normal lids □lid edema □redness □PEERLA

Hearing: □normal □ABN□AID **Nose**:□sinus □tenderness □normal □discolored □on oxygen □spider veins

Mouth: **Dentures**: □Yes □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 □disoriented □trembling □neuropathy □stroke □weakness

Psych: □normal mood □depression □anxious □agitated □flat □argumentative □litigious

Speech: □normal □loud □stutter □slowed □flat

Tobacco Use: □never used tobacco □current amount/freq._____ □previously…how long_____

Pneumonia Vaccine: □Yes □No If no, why not? _____

Colorectal Exam: □Y □N Year:_____ **Mammogram:** □Y □N Year:_____

Pressures	Right	Left
Doppler	_____	
PT	_____	
DP	_____	
Index	_____	
Index	_____	

Palpable pulse	Right	Left
PT	Y/N	Y/N
DP	Y/N	Y/N
Radial	Y/N	Y/N
Graft/Fistula	Thrill	No Thrill

Smoking Counseling? ☐Yes ☐No

Physician Recommendations/Orders: _____

_____

ART-UNI ART-BILAT VENOUS-UNI VENOUS-BILAT CAROTID ABDOMINAL VEIN MAP: Upper / Lower HEMODIALYSIS