



Welcome to WellStar Medical Group! Thank you for choosing us and entrusting us with your healthcare needs. We do not take your choice or your trust for us for granted. We are dedicated to bringing WellStar's expansive world of medical knowledge to you in your neighborhood. By choosing a WellStar physician or facility, you have become a partner with us in pursuing the most appropriate, medically advanced treatment available to you today. Our mission is to provide world-class cardiovascular surgical care and outcomes through state-of-the art, high quality service delivery. Our partnership with you depends on it. Our history of high standards demands it.

Please understand that our surgeons spend a great deal of time performing surgeries and evaluating patients at the hospital. As a result, patients are seen in clinic on Monday afternoons, Tuesday and Wednesday mornings, and Thursday afternoons. We appreciate your understanding and stress that while our clinic hours are limited, you can expect to receive exceptional, one-on-one attention at all of your visits. Please be advised that it is likely for you to be seen by other practitioners during your visit.

Since you have scheduled an appointment with WellStar Cardiovascular Surgery, there is important information you need to know. Our office is located at 61 Whitcher Street, Suite 4100, Marietta, GA 30060. Our office is open Monday through Friday from 8:30am to 5:00pm, excluding holidays. Call our office at 770-590-4180 to schedule or change an existing appointment. To contact your cardiovascular surgeon, you should call the office during regular office hours, and a representative will take a message for your call to be returned. **If you have a life-threatening emergency, please call 911.**

Here is a checklist of what to bring to your appointment:

Accurate identification and contact information

If you have a change in home address, phone number, medical insurance, employer, etc. between the time that your appointment was scheduled and the day of your appointment, please notify us. We also require a copy of your photo ID. The accuracy of your medical record and the billing process depends on this information.

Insurance card

We will obtain a copy of your insurance card at your first visit for your medical record. We will also need to obtain an updated copy of your card if there are any changes to your insurance during the time that we are providing you with care.

Referral authorizations

Sometimes these are required by your insurance company before you can see a provider. Please contact your insurance company to see if this is necessary for your visit, and let us know when a referral is obtained.

Copayment

Copayment will be collected during check in. Payment is accepted in the form of cash, check, debit card, or credit card (Visa, MasterCard, Discover, and American Express).

List of current medications

Please complete the medication list in this packet in its entirety prior to your visit. It might be helpful for you to bring all of your medications in their pharmacy containers to your visit to ensure that the medication list is complete and accurate.

Any test results, images, and other materials that may be helpful to your provider

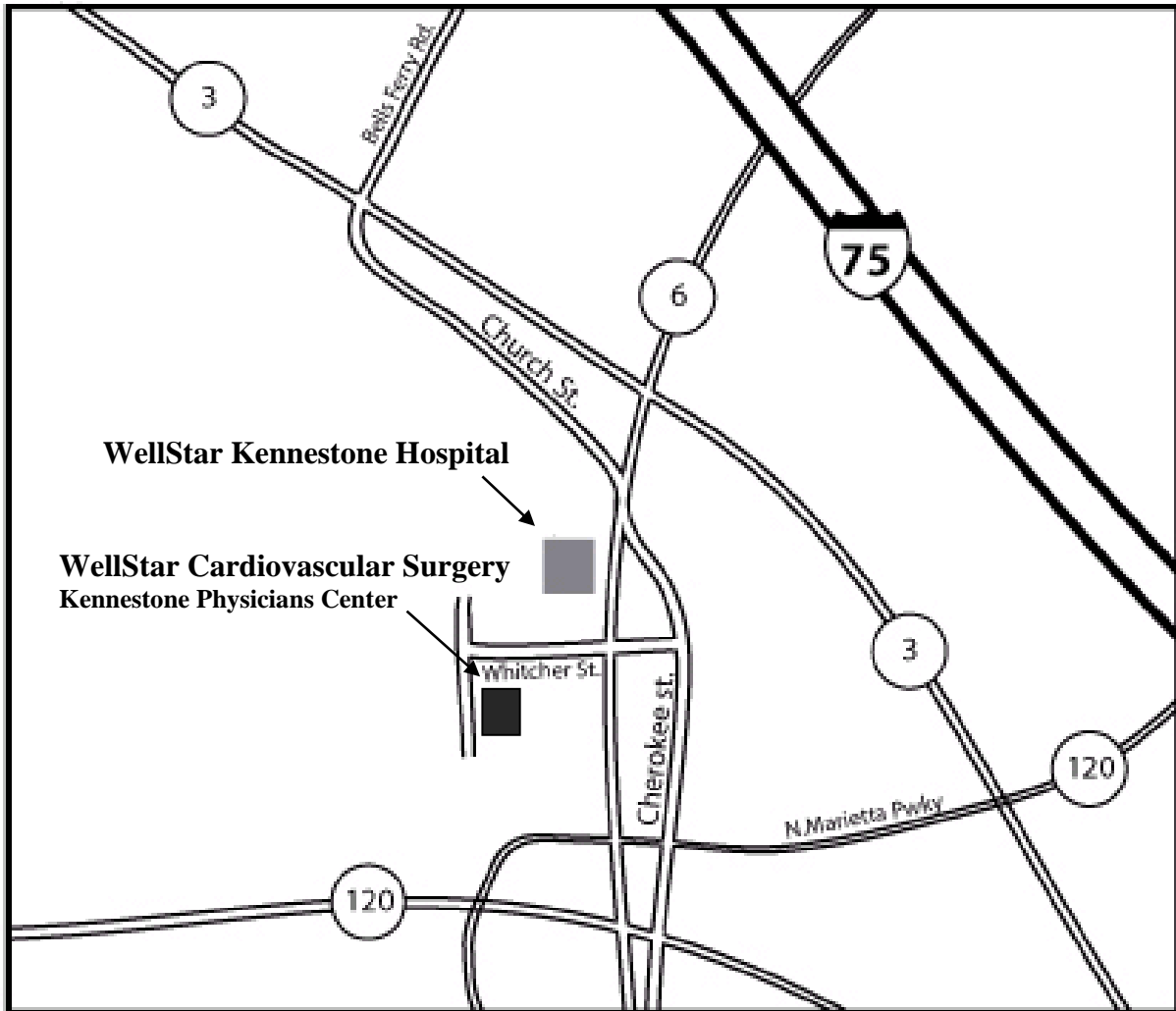
Parking payment

Parking in the patient/visitor deck is \$5 (max), and valet parking is \$5 (flat rate). Cash, credit cards, and debit cards are accepted for the parking deck. Only cash is accepted for valet parking.

Please visit our website at www.wellstar.org for more information on your physician. You can also find information specifically related to your visit in the following pages.

Thank you again for choosing us, and we look forward to caring for you.

61 Witcher Street
Suite 4100
Marietta, GA 30060



From I-75 North or South:

Take Exit 267B which is the exit for Kennestone Hospital. After you come off the exit, go to the 3rd traffic light on Church Street and take a right onto Witcher Street. Then make a left into the Kennestone Physicians Center Office Building which is connected with an overhead walkway to Kennestone Hospital. We are located in the 61 building in Suite 4100 on the 4th floor.

Area Lodging

The following is a listing of hotels and motels in and around the Marietta area:

Marietta

Days Inn

753 North Marietta Hwy
678-797-0233

Metro Extended Stay

184 Freys Gin Road
770-281-0100

Hilton Atlanta/Marietta Hotel

500 Powder Springs Road
866-920-8082

Kennesaw

Quality Inn

750 Cobb Place
770-419-1530

LaQuinta Inn

2625 George Busbee Pkwy
770-426-0045

Red Roof Inn – Atlanta Town Center

520 Roberts Court SW
770-429-0323

Super 8 Motel

610 Franklin Road
770-919-2340

Days Inn

760 Cobb Place Blvd
770-419-1576

Ramada Suites

630 Franklin Road
770-919-7878

Townplace Suites

1074 Cobb Place Blvd NW
770-794-8282

Holiday Inn Express

1250 Franklin Road
800-230-4134

Homewood Suites

905 Cobb Place Blvd
678-354-2800

Baymont Inn and Suites

639 Franklin Road SE
678-355-5050

Hilton Garden Inn

895 Cobb Place Blvd
678-322-1140

Sun Suites

3174 Barrett Lakes Blvd
770-424-5410

Comfort Inn

2489 George Busbee Pkwy
770-499-9200

Comfort Suites

3366 Busbee Drive NW
678-275-2090

FOR OFFICE USE

New Patient Information

Name: _____ Date of Birth: _____

PRIMARY CARE PHYSICIAN

Name: _____ Phone #: _____
Address: _____ County: _____
City: _____ State: _____ Zip Code: _____

REFERRING PHYSICIAN

Name: _____ Phone #: _____
Address: _____ County: _____
City: _____ State: _____ Zip Code: _____

What problems bring you to our clinic?

Symptoms	Onset Date
_____	_____
_____	_____
_____	_____
_____	_____

Have you been in the hospital within the last 60 days? Yes No

Please list any major illnesses, hospitalizations, or surgical procedures that you have had:

Major Illness/Hospitalization/Surgical Procedure	Date	Body Part/Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name: _____

Date of Birth: _____

MEDICAL PROBLEMS (please check all conditions that apply):

Neurological

- Stroke/TIA
- AVM
- Brain Injury at Birth
- Brain Infection
- Brain Tumor
- Traumatic Brain Injury
- Seizures w/ Fever in Childhood
- Developmental Delay
- Parkinson's Disease
- Tremor
- Dystonia
- Ataxia
- Hydrocephalus
- Dementia
- ALS/ Lou Gehrig's
- Myasthenia Gravis
- Neuropathy
- Muscle Disease
- Spinal Cord Disease
- Multiple Sclerosis
- Migraine
- Restless Legs
- Sleep Apnea
- Narcolepsy
- Optic Neuritis
- Epilepsy
- Other: _____

Rheumatologic

- Rheumatoid Arthritis
- Lupus
- Vasculitis
- Spinal Stenosis
- Cervical Spondylosis
- Other: _____

Cardiovascular

- Hypertension
- High Cholesterol
- Angina/Heart Attack
- Arrhythmia
- Syncope
- Peripheral Vascular Disease
- Heart Failure
- Other: _____

Gastrointestinal

- Reflux/Heartburn
- Peptic Ulcer Disease
- Crohn's Disease
- Ulcerative Colitis
- Other: _____

Cancer

- Lung
- Breast
- Brain
- Prostate
- Skin
- Colon/Rectum
- Lymphoma
- Other: _____

Endocrine

- Thyroid Disease
- Osteoporosis
- Diabetes
- Other: _____

Hematological

- Iron Deficiency
- Sickle Cell Disease
- Anemia
- Other: _____

Psychiatric

- Depression
- Bipolar
- Anxiety
- Panic Attack
- Schizophrenia
- Other: _____

Respiratory

- Asthma
- Emphysema
- Tuberculosis
- Sarcoidosis
- Other: _____

Genitourinary

- Kidney Failure
- Kidney Stones
- Prostatic Hyperplasia
- STD
- Urinary Tract Infection
- Other: _____

Please list other medical problems not listed above:

Name: _____

Date of Birth: _____

FAMILY HISTORY

	Alive (Current Age)	Deceased (Age)	Cause of Death	Illnesses/Diseases
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
Children	_____	_____	_____	_____
Other:	_____	_____	_____	_____

How many immediate relatives lived to be 65+ years old? _____

SOCIAL HISTORY

Education Level: High School College Graduate Degree

Marital Status: Married Divorced Separated Widowed Single

Currently Employed: Yes No Present Occupation: _____

Do you have disability claims? Yes No

Alcohol Use: Yes No Type: _____ # Drinks/Week: _____

Tobacco Use: Yes No Type: _____ # Packs/Day: _____ Last Use: _____

Illicit Drug Use: Yes No

Type: _____ Route: _____ Frequency: _____ Last Use: _____

Physical Activity: Yes No Type: _____ Days/Week: _____ Mins/Day: _____

How many times have you fallen in the last year? _____ Were you injured? Yes No

Name: _____

Date of Birth: _____

REVIEW OF SYSTEMS (please check any of the systems you HAVE NOW or have had IN THE PAST MONTH):

Neurological

- Dizziness
- Droopy Eyes
- Muscle Twitching
- Weakness
- Numbness
- Tingling
- Memory Loss
- Blackouts/Seizures
- Unsteadiness
- Head Injury
- Slurred Speech
- Daytime Sleepiness
- Insomnia
- Restless Legs
- Leg Movement During Sleep
- Trouble Walking

HEENT

- Glasses
- Eye Redness
- Eye Dryness
- Watery Eyes
- Eye Pain
- Eye Infection
- Blurry Vision
- Double Vision
- Bleeding Gums
- Sore Throat
- Sore Tongue/Mouth
- Difficulty Swallowing
- Hoarseness
- Sinus Trouble
- Ear Pain
- Ear Infection/Discharge
- Ringing in Ears
- Hearing Difficulty
- Dizziness
- Headache
- Post-Nasal Drainage/Hay Fever

Genitourinary

- Painful Urination
- Blood in Urine
- Urine Retention
- Urine Incontinence
- Frequent Urination
- Excessive Menstrual Bleeding
- Menstrual Irregularities
- Sexual Dysfunction
- Testicular Pain
- Testicular Mass
- Painful Intercourse

Cardiovascular

- Fainting
- Chest Pain/Angina
- Aneurysm
- Palpitations
- Ankle Swelling
- Hand/Foot Discoloration
- Poor Circulation
- Heart Murmur

Respiratory

- Cough
- Blood in Cough
- Congestion
- Shortness of Breath
- Wheezing
- Snoring
- Sputum

Skin

- Rash
- Skin Color Change
- Hair Loss
- Skin Ulcer
- Brittle Nails
- Bruising
- Change in mole/wart
- Hives
- Itching
- Poor Sore/Wound Healing

Musculoskeletal

- Joint Pain
- Joint Swelling
- Joint Stiffness
- Back Pain
- Muscle Aches
- Loss of Strength
- Decreased Range of Motion

Endocrine

- Cold Intolerance
- Heat Intolerance
- Excessive Thirst
- Sweating

Gastrointestinal

- GI Bleed
- Nausea/Vomiting
- Hepatitis
- Heartburn
- Diarrhea
- Constipation
- Abdominal Pain
- Blood in Stool
- Black Stool
- Excessive Gas

General

- Weakness
- Tiredness
- Loss of Appetite
- Increased Appetite
- Weight Gain
- Weight Loss
- Chills
- Fever
- Night Sweats
- Frequent Infections

Psychiatric

- Psychosis
- Addictions
- Anxiety
- Hallucinations
- Severe Stress
- Depression
- Mental Illness
- Mood Swings
- Phobias
- Change in Sleep Pattern

Hematologic

- Easy Bruising
- Abnormal Bleeding
- Nosebleeds

Name: _____

Date of Birth: _____

ALLERGIES & MEDICATIONS

Your pharmacy name: _____

Pharmacy phone #: _____ Pharmacy fax #: _____

Please list any allergies you have (drugs and other substances):

Drug/Substance	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Please list ALL medications that you are taking:

Medication (Name, Dose, Route, Frequency) List the name of your medications, the doses, the method or route used to take the medications, and the frequency with which you take them The reconciliation section will be completed by your provider	Reconciliation											
	C = Continue A = Acknowledged D = Discontinue											
	C	A	D	C	A	D	C	A	D	C	A	D

Reviewed by: _____

Reconciled by: _____

Date: _____

Name: _____

Date of Birth: _____

Are you experiencing pain at the present time? Yes No

If yes, please indicate the location of the pain: _____

Indicate your current pain level on the following scale:

