DOUGLAS NEUROLOGY ASSOCIATES, P.C.

DOUGLAS OFFICE LOCATION
4586 TIMBER RIDGE DRIVE, SUITE 140
DOUGLASVILLE, GA 30135

DIRECTIONS:

FROM WELLSTAR DOUGLAS HOSPITAL: TURN LEFT ONTO PRESTLEY MILL ROAD. GO OVER THE 1-20 BRIDGE. ON THE LEFT AT THE CORNER OF PRESTLEY MILL ROAD AND TIMBER RIDGE DRIVE YOU WILL SEE A RED BRICK BUILDING. THE NAME OF THE BUILDING IS PRESTLEY MILL FOREST.

I-20 WEST BOUND FROM ATLANTA: TAKE EXIT 36 (CHAPEL HILL ROAD) STAY IN THE RIGHT LANE. TURN RIGHT ONTO CHAPEL HILL ROAD. STAY IN THE FAR RIGHT LANE AND BEAR AROUND TO THE RIGHT. AT THE FIRST TRAFFIC LIGHT TURN RIGHT. THIS WILL BE PRESTLEY MILL ROAD. GO APPROX. 2 BLOCKS PAST WELLSTAR DOUGLAS HOSPITAL. GO OVER I-20 BRIDGE. YOU WILL SEE A RED BRICK BUILDING ON THE LEFT AT THE CORNER OF PRESTLEY MILL ROAD AND TIMBER RIDGE DRIVE. THE NAME OF THE BUILDING IS PRESTLEY MILL FOREST.

I-20 EAST BOUND FROM CARROLLTON: TAKE EXIT 36 (CHAPEL HILL ROAD) TURN RIGHT AND IMMEDIATLEY GET INTO THE FAR LEFT TRUN LANE. TURN LEFT ONTO TIMBER RIDGE DRIVE. YOU WILL SEE A QT STATION. GO EAST APPROX. ¼ MILE. TURN RIGHT ONTO PRESTLEY MILL ROAD AND GO ABOUT 200 FT. YOU WILL SEE A RED BRICK BUILDING ON THE LEFT. IT IS ON THE CORNER OF PRESTLEY MILL ROAD AND TIMBER RIDGE DRIVE. THE NAME OF THE BUILDING IS PRESTLEY MILL FOREST.

HWY 92 FROM HIRAM: TAKE HIRAM DOUGLASVILLE HWY./92/TRAVIS TRITT HWY. TOWARD DOUGLASVILLE. GO STRAIGHT APPROX. 7.5 MILES. STAY STRAIGHT ONTO CAMPBELLTON STREET. GO PAST DOUGLAS COUNTY HIGH SCHOOL. TURN LEFT ONTO PRESTLEY MILL ROAD. GO STRAIGHT APPROX 1 MILE. GO PAST WELLSTAR DOUGLAS HOSPITAL AND OVER I-20 BRIDGE. YOU WILL SEE A RED BRICK BUILDING ON THE LEFT. IT IS ON THE CORNER OF TIMBER RIDGE DRIVE AND PRESTLEY MILL ROAD. THE NAME OF THE BUILDING IS PRESTLEY MILL FOREST.

JUST A REMINDER...

______________________________ HAS AN APPOINTMENT SCHEDULED WITH DANIEL ZDONCZYK, MD OR PREETHI NATARAJAN, MD ON ______________________________ AT ______________________.

*** PLEASE COMPLETE THE NEW PATIENT PAPERWORK PRIOR TO YOUR SCHEDULED APPOINTMENT.

*** ADDITIONAL INFORMATION WILL NEED TO BE COMPLETED ON THE DATE OF YOUR APPOINTMENT. **PLEASE ARRIVE 15 MINUTES EARLY**.

DOUGLAS NEUROLOGY ASSOCIATES, P.C.

MARIETTA OFFICE LOCATION

3834 AUSTELL ROAD
SUITE B
MARIETTA, GA 30008

DIRECTIONS:

FROM DOUGLASVILLE: TAKE I-20 EAST. TAKE EXIT 44 FOR GA-6/THORNTON ROAD TOWARD AUSTELL. TURN LEFT ONTO GA-6/THORNTON ROAD. TURN RIGHT ONTO MAXHAM ROAD. CONTINUE ONTO GA-5/AUSTELL ROAD. OUR OFFICE WILL BE ON THE LEFT OF AUSTELL ROAD NEXT TO THE CAPTAIN D'S.

FROM VILLA RICA: TAKE I-20 EAST. TAKE EXIT 44 FOR GA-6/THORNTON ROAD TOWARD AUSTELL. TURN LEFT ONTO GA-6/THORNTON ROAD. TURN RIGHT ONTO MAXHAM ROAD. CONTINUE ONTO GA-5/AUSTELL ROAD. OUR OFFICE WILL BE ON THE LEFT OF AUSTELL ROAD NEXT TO THE CAPTAIN D'S.

FROM HIRAM: TAKE JIMMY LEE SMITH PARKWAY/US 278 E. TURN LEFT ONTO RICHARD D SAILORS PARKWAY. CONTINUE ONTO POWDER SPRINGS ROAD. TURN RIGHT ONTO THE EAST WEST CONNECTOR. TURN LEFT ONTO AUSTELL ROAD. OUR OFFICE WILL BE ON THE LEFT OF AUSTELL ROAD NEXT TO THE CAPTAIN D'S.

FROM ROCKMART: TAKE US-278 E FOR APPROX. 20 MILES. TURN LEFT ONTO RICHARD D SAILORS PARKWAY. CONTINUE ONTO POWDER SPRINGS ROAD. TURN RIGHT ONTO THE EAST WEST CONNECTOR. TURN LEFT ONTO AUSTELL ROAD. OUR OFFICE WILL BE ON THE LEFT OF AUSTELL ROAD NEXT TO THE CAPTAIN D'S.

FROM CARTERSVILLE: TAKE I-75 S. TAKE EXIT 367B TOWARDS MARIETTA. MERGE ONTO GA-5 S/CANTON ROAD CONNECTOR NE/STATE ROUTE 5 SPUR. CONTINUE TO FOLLOW GA-5 S. TURN RIGHT ONTO NORTH MARIETTA PARKWAY NW. CONTINUE ONTO SOUTH MARIETTA PARKWAY SW. CONTINUE ONTO POWDER SPRINGS ROAD SW. TURN LEFT ONTO SANDTOWN ROAD SW. TURN RIGHT ONTO GA-5/AUSTELL ROAD. OUR OFFICE WILL BE ON THE RIGHT OF AUSTELL ROAD JUST BEFORE THE CAPTAIN D'S.

JUST A REMINDER...

______________________________ HAS AN APPOINTMENT SCHEDULED WITH DANIEL ZDONCZYK, MD OR PREETHI NATARAJAN, MD ON ______________________________ AT ____________________.

*** PLEASE COMPLETE THE NEW PATIENT PAPERWORK PRIOR TO YOUR SCHEDULED APPOINTMENT.

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DOUGLAS NEUROLOGY ASSOCIATES, P.C.

PAULDING OFFICE LOCATION

148 BILL CARRUTH PARKWAY, SUITE 120
(PINNACLE ORTHOPAEDIC SUITE)
HIRAM, GA 30141

DIRECTIONS:

FROM DOUGLASVILLE: TAKE GA-92N APPROXIMATELY 6 MILES. TURN LEFT ONTO BILL CARRUTH PARKWAY. CONTINUE STRAIGHT ON BILL CARRUTH PARKWAY FOR APPROX. 5 MILES. WE ARE LOCATED IN THE WELLSTAR BUILDING ON THE CORNER OF BILL CARRUTH AND HWY. 278.

FROM VILLA RICA: TAKE HWY. 61 N FOR 12.6 MILES. TURN RIGHT ONTO JIMMY CAMPBELL PKWY. /HWY. 278. TURN RIGHT ONTO BILL CARRUTH PARKWAY. WE ARE LOCATED IN THE WELLSTAR BUILDING ON THE CORNER OF BILL CARRUTH PARKWAY AND HWY. 278.

FROM POWDER SPRINGS: TAKE HWY. 278/C.H. JAMES PKWY. WEST FOR 4.8 MILES. TURN LEFT ONTO BILL CARRUTH PARKWAY. WE ARE LOCATED IN THE WELLSTAR BUILDING ON THE CORNER OF BILL CARRUTH PARKWAY AND HWY. 278.

FROM ROCKMART: TAKE HWY. 278 E/S-GA6 FOR 15.3 MILES. TURN RIGHT ONTO BILL CARRUTH PARKWAY. WE ARE LOCATED IN THE WELLSTAR BUILDING ON THE CORNER OF BILL CARRUTH PARKWAY AND HWY. 278.

FROM CARTERSVILLE: TAKE HWY. 61S/DALLAS HWY. SW 15.8 MILES. TURN LEFT ONTO HWY. 278 APPROXIMATELY 3 MILES. TURN RIGHT ONTO BILL CARRUTH PARKWAY. WE ARE LOCATED IN THE WELLSTAR BUILDING ON THE CORNER OF BILL CARRUTH PARKWAY AND HWY. 278.

JUST A REMINDER…

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*** PLEASE COMPLETE THE NEW PATIENT PAPERWORK PRIOR TO YOUR SCHEDULED APPOINTMENT.

*** ADDITIONAL INFORMATION WILL NEED TO BE COMPLETED ON THE DATE OF YOUR APPOINTMENT. **PLEASE ARRIVE 15 MINUTES EARLY.**

Medical Information

Name: ______________________ Age: ______ Today's Date: ______________

Referring Physician ______________________ Phone # ______________
(Complete Name)

Primary Care Physician ______________________ Phone # ______________
(Complete Name)

PLEASE LIST THE SYMPTOMS FOR WHICH YOU ARE SEEING THE NEUROLOGIST TODAY:

____

____

____

PLEASE CHECK IF YOU HAVE ANY OF THE SYMPTOMS LISTED IN THE LAST 6 MONTHS

SKIN

__ Rash

HEENT

__ Double Vision
__ Hoarseness
__ Ringing Ears
__ Hearing Loss
__ Loss of Smell
__ Visual Loss
__ Loss of Taste

RESPIRATORY

__ Snoring
__ Wheezing
__ Shortness of Breath
__ Stop Breathing During Sleep
__ Excessive Daytime Sleepiness

NECK

__ Persistent Neck Pain

CARDIOVASCULAR

__ Chest Pain
__ Palpitations
__ Shortness of Breath

GASTROINTESTINAL

__ Diarrhea
__ Abdominal Pain
__ Bloody Stools
__ Difficulty Swallowing

NEUROLOGY

__ Confusion
__ Memory Loss
__ Tremors
__ Passing Out
__ Dizziness
__ Slurred Speech
__ Incoordination
__ Falls
__ Difficulty Sleeping
__ Convulsions
__ Numbness/Tingling
__ Tingling of Leg/Discomfort During Sleep
__ Headache (Persistent)
__ Back Pain

GENITOURINARY

__ Blood in Urine
__ Urinary Urgency

PSYCHIATRIC

__ Depression

Have you had any recent tests or x-rays?
(CT, MRI Scans, EEG, Etc). Type of Test/Date/Where

1. ______________________________
2. ______________________________
3. ______________________________

Past Medical History: Please List Your Medical Illnesses Diagnosed in the Past: Date/Age

1. ______________________________
2. ______________________________
3. ______________________________

Surgeries in the past: Date / Age

1. ______________________________
2. ______________________________
3. ______________________________

Current Medications: Strength & How Many Per Day:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Allergies/Reactions:

1. ______________________________
2. ______________________________

Pharmacy Name & Phone Number: ______________________________

FAMILY HISTORY:

Does anyone in your immediate family have one of the following? Specify Father, Mother, Etc.

Diabetes ______________________________

Heart Disease ______________________________

High Blood Pressure ______________________________

Stroke ______________________________

Epilepsy/Seizures ______________________________

Thyroid Disease ______________________________

Elevated Cholesterol ______________________________

Migraine Headaches ______________________________

SOCIAL HISTORY:

Occupation: ______________________________

Tobacco Use:	Type: __________	Amount: __________	Number of Years: __________
Alcohol Use:	Type: __________	Amount: __________	Number of Years __________
Illicit Drug:	Type: __________	Amount: __________	Number of Years: __________

Do you have any barriers to learning: ______________

If yes please explain: ______________________________

Do you have any religious beliefs that would warrant us to treat you in a special manner? __________

If yes please explain: ______________________________

Do you have an advanced directive? ______________

If yes may we have a copy? ______________

Date: ______________ Physician Signature: ______________________________

PATIENT INFORMATION *(Please Print)*

Last Name ______________________________

First Name ____________________ MI ______

SSN ______________________________

DOB ______________________________

Sex ______________________________

Marital Status ______________________________

Race ______________________________

Address ______________________________

City ______________________________

State ______________ Zip Code __________

Email ______________________________

____

Referring Doctor ______________________________

PCP ______________________________

INSURANCE

Primary Insurance Co. ______________________________

Insurance Claim Address ______________________________

Contract # ______________________________

Group # ______________________________

Secondary Insurance Co. ______________________________

Insurance Claim Address ______________________________

Contract # ______________________________

Group # ______________________________

INSURED PERSON INFO:

Name ______________________________

DOB ____/____/_____ SSN ______________________________

Name of Employer ______________________________

Insurance through Employer? ______________

Active Duty? ______________ FT? ______________

Not Employed? ______________ PT? ______________

Retired? ______________ Self Employed? ______________

Student? ______________ FT? __________ PT? __________

Driver's License# ______________________________

HIPPA Password ______________________________

HIPPA Relationship ______________________________

PATIENT

Home Phone ______________________________

Cell Phone ______________________________

Work Phone ______________________________

____

Third Party Information ______________________________

Worker's Comp-Case Nurse Manager ______________________________