DECO
DIABETES & ENDOCRINOLOGY CENTER OF OHIO, INC.
EST. 2005

Patient Name: _____

Is scheduled for an appointment with:

☐ Dr. Pallavy Reddy

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

_____ at _____ AM/PM

Our office phone number is 614-764-0707

- ***Please ARRIVE 15 minutes prior to your scheduled appointment time****. Late arrivals may require rescheduling.*
- ***A current insurance card, prescription coverage card (if applicable), photo identification and any copay or coinsurance are required at check-in.*** *If your insurance should change before your scheduled appointment, please call the office to ensure that we are a provider in your new network.*
- ***Patient with diabetes must bring their meter and/or devices for downloading and review; these are required at every appointment.***

PLEASE MAIL YOUR COMPLETED PAPERWORK TO OUR OFFICE:

DECO, Inc.
7281 Sawmill Road
Dublin, Ohio 43016
You can also fax your paperwork to 614-764-1707

OUR OFFICE PHONE HOURS ARE:
Mon – Wed 8:00 am – 12:00 pm and 1:00 pm – 3:00 pm, Thurs 8:30 am - 12:00 pm and 1:00 pm – 5:00 p.m., and Fri 8:00 am – 12:00 pm and 1:00 pm – 2:00 pm

PLEASE NOTE: You cannot see our office from Sawmill Rd. Our office is in an office park at the corner of Sawmill Rd. and Bright Rd/Sawbury Rd. (just north of 270 off Sawmill Rd.) You will turn LEFT at the second traffic light (Bright Rd), if you are northbound on Sawmill. (There is a BP gas station at this intersection.) Then, you will turn RIGHT into our office park. The office park has several other one-story buildings. Our Building is 7281 and there are signs in the windows for DECO, Inc. If you are traveling Northbound on Sawmill Rd and you get to Hard Rd, you've gone one intersection too far. You enter our office park from Bright Road. We are then the first building on the left.

DECO is a proud partner of Privia Health and Privia Medical Group of Ohio

PRIVIA HEALTH

Please print clearly and complete form in entirety

Patient Demographics

First Name	Last Name		MI	Date of Birth
Address	**City**	**State**	**Zip**	**SSN#**

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner

Gender: ☐ Female ☐ Male ☐ Transgender

Ethnicity: ☐ Hispanic/Latino ☐ Non- Hispanic/Latino ☐ Decline to Specify

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Asian Indian ☐ Black or African American
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other Pacific Islander ☐ Decline to Specify ☐ Other _____

PLEASE CHECK PRIMARY PHONE

Home Phone ☐	Cell Phone ☐

Ok to leave message? ☐ Yes ☐ No If so, what kind? ☐ Extended ☐ Brief

Email Address:

Preferred Contact: ☐ Home Phone ☐ Cell Phone

Patient's Preferred Name:

Insurance Information

Primary Insurance Company	Effective Date		Secondary Insurance Company	Effective Date	
Claims Mailing Address (Street or Box)			**Claims Mailing Address (Street or Box)**		
City	**State**	**Zip**	**City**	**State**	**Zip**

Policy ID	Group ID	Policy ID	Group ID
Subscriber Name (Policy Holder)	**DOB**	**Subscriber Name (Policy Holder)**	**DOB**
Subscriber SSN	**Relationship to Patient**	**Subscriber SSN**	**Relationship to Patient**

Emergency Contact

Relationship to Patient:
Ex: Wife, Daughter

First Name	Last Name		MI	Date of Birth
Address		**City**	**State**	**Zip**
Home Phone	**Cell Phone**		**Work Phone**	

Please print clearly

Pharmacy Information		
	Mail Order Pharmacy	**Local Pharmacy**
Name:		
Address:		
Phone:		
Fax:		

Medications & Vitamins/Supplements (including insulin, birth control such as IUDs, etc). Attach additional sheets if needed	
Medication Name	**Dosage**

Medications Tried and Failed	
Medication Name	**Dosage**

Medication Allergies – List all known allergies and reactions	
Medication Name	**Reaction**

Please print clearly

Past / Present Medical History **Please list all current and previous diagnoses medical conditions – please include year of diagnosis if known**

Hospitalizations		
☐ **I have never been hospitalized**		
Date:	Hospital:	Reason:

Surgeries		
☐ **I have never had a surgery**		
Date:	Hospital:	Reason:

Please print clearly

Family History

Check if any family member(s) has had any of the following conditions

☐ Adopted					Other Family			
Diagnosis	**Mother**	**Father**	**Brother**	**Sister**				
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐	☐
Cancer – Type:	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes - ☐ Type 1 ☐ Type 2	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Hyperlipidemia (High Cholesterol)	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension (High Blood Pressure)	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐

Imaging

Check if you have received the following, and date and location of most recent exam

Exam	**Date**	**Doctor/Location of Test**
☐ **DEXA Scan/ Bone Density Test**		
☐ **Thyroid Ultrasound**		
☐ **MRI of the brain**		
☐ **CT of the abdomen**		

Social History

Number of pregnancies? _____ ☐ N/A	Number of children? _____ ☐ N/A

Tobacco Use ☐ No	☐ Social ☐ Light ☐ Heavy ☐ Former/Year Quit_____ ☐ Chewing ☐ Pipe ☐ Cigar ☐ Cigarette
Alcohol Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year Quit_____ ☐ Beer ☐ Wine ☐ Liquor
Exercise Activity ☐ None	☐ Moderate ☐ Vigorous Days/Week_____
Special Diet ☐ No	☐ Diabetic ☐ Vegan ☐ Gluten Free ☐ Low Salt ☐ Vegetarian ☐ Low Sugar ☐ Other: _____

Advanced Directive/Care Plan

Please select one, provide any supporting documents to office upon check-in

☐ NONE (No Advanced Directive)	☐ POA (Power of Attorney)
☐ LW (Living Will)	☐ DEC (Surrogate Decision Maker Assigned)
☐ DNR (Do Not Resuscitate)	

Please print clearly

Care Team	Name of Physician/Provider	Are they part of a Health System? *(OhioHealth, OSU, COPC, Mt Carmel)*	Phone Number	Fax Number
Primary Care				
OB/GYN				
Ophthalmologist Or Optometrist				
Podiatrist				
Cardiologist				
Nephrologist				
Gastroenterologist				
Other:				

Employment Information

☐ Full-time ☐ Part-time ☐ Retired ☐ Not Employed ☐ Self-Employed ☐ On Active Military Duty ☐ Veteran

Employer Name		**Job Title**		**Work Phone**
Address		**City**	**State**	**Zip**
Student? ☐ Yes ☐ No	☐ Full-time ☐ Part-time	**School**		

DECO Consultation Questionnaire

NAME _____ **DOB**_____

How did you hear about our practice?

_____

What is the reason for your visit?

_____

How long have you had this problem?

_____

When was this problem discovered?

- How was it discovered? _____
- What symptoms were/are you having with this problem? _____

What is your main concern or question that you want the doctor to address at your visit?

_____

Have you seen an Endocrinologist for this? ☐ **Yes** ☐ **No** **If Yes, please list name(s)** _____

Have you seen other types of specialists for this problem? ☐ **Yes** ☐ **No** **If Yes, please specify** _____

What tests have been done for **this problem**? Check all that apply and list where performed and results:

☐ Blood/Urine Tests _____

☐ X-Rays or Bone Density Test _____

☐ CT or MRI Scans _____

☐ Ultrasounds _____

- Biopsy _____

☐ Nuclear Medicine Scans _____

What treatments have you received for this problem? Provide details and response to treatment:

☐ Diet /Exercise_____

☐ Vitamins/Supplements_____

☐ Medications_____

☐ Surgery_____

☐ Other_____

CANCELLATION AND NO-SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide more than 24 hours' notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. When cancellations are made with less than 24 hours' notice, we are unable to offer that slot to other patients.

Any three of the following: no shows, late arrivals, or same day cancellations may lead to a discharge from the practice. No-show appointments or appointments which are cancelled less than 24 hours in advance may be subject to a cancellation fee ranging from $10-$75 depending on the services scheduled. Procedure cancellations require 3-4 business days' notice, without notification they may be subject to a $75.00 cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as NO SHOW. A NO-SHOW fee will be assessed to your account ranging from $10-$75 depending on the services scheduled. Patients who No-Show, cancel, or reschedule with high frequency are subject to dismissal from the practice.

The cancellation and no-show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to the practice manager, 614-764-0707.

Please sign that you have read, understand, and agree to this Cancellation and No-Show Policy.

_____ _____

Patient Name (Please Print) Date of Birth

_____ _____

Signature of Patient Date