____

Is scheduled for an appointment with:

Dr. Jennifer Rittenberry

_____ Monday ______ Tuesday ______ Wednesday ______ Thursday _____ Friday

______________________________ at __________________ AM/PM

- *Please plan to arrive 10 minutes prior to your scheduled appointment time to allow for paperwork processing and check in procedures.*
- *If you are unable to arrive by your scheduled appointment time, it may be necessary to reschedule your appointment.*
- *A current insurance card and photo identification must be presented at check-in.*

In order to expedite the check-in process, please complete the attached paperwork prior to your appointment. You may fax your completed paperwork to (614)764-1707 or you may mail it to:

DECO, Inc.
7281 Sawmill Rd., Ste 100
Dublin, Ohio 43016

If you have any questions regarding this paperwork or your visit, please contact our office at
614.764.0707
We are here to assist you Monday – Friday from 8:30am – 4:30pm

Our staff will be happy to assist you Monday – Friday 8:30am - 4:30pm

614.764.0707

614.764.1707 Fax

Dr. Rittenberry received her medical degree from the University of Texas in Galveston, Texas. She then completed her Internal Medicine Residency as well as her Endocrinology & Metabolism Fellowship at The Ohio State University Medical Center in Columbus, Ohio. Dr. Rittenberry is Board Certified in Endocrinology and Internal Medicine.

Dr. Rittenberry's Professional Memberships include: American Association of Clinical Endocrinologists, The Endocrine Society, American College of Physicians, and the American Medical Association

Our office is conveniently located in Northwest Columbus at:

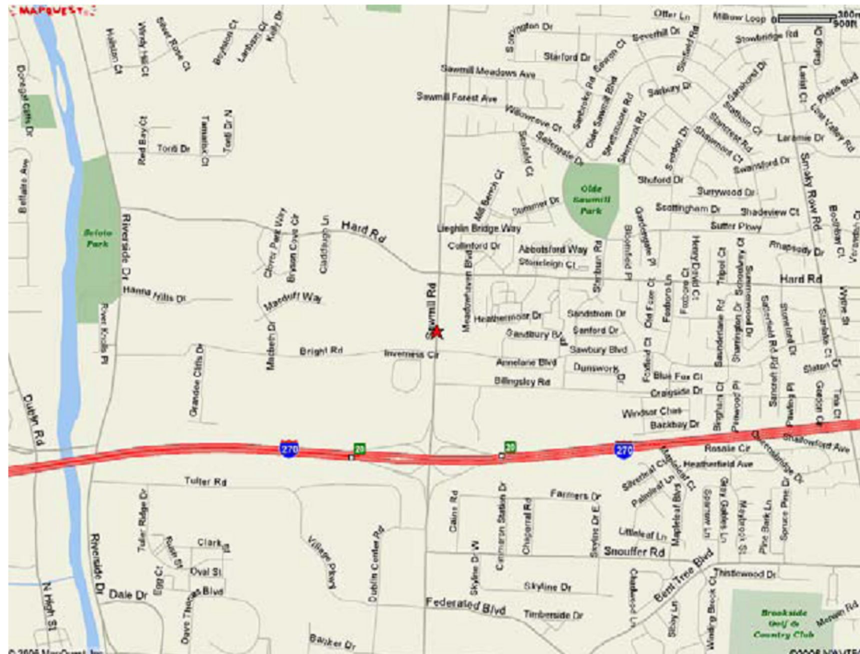
7281 Sawmill Rd – Suite 100 (Driveway off Bright Rd.)

Dublin, Ohio 43016

From 1-270, Exit Sawmill Rd. – Head North on Sawmill

Turn left on Bright/ Sawbury Rd.

We are the first driveway on the right, 1st building on the left.



Patient Registration

Name (Last) ______________________ (First) __________________________ (MI) ______

SSN ____________________ Date of Birth _____________ Martial Status__ S__M__ D__ W

Address ____ Sex ___M ___F

City ____________________________________ ST _________ Zip ____________

Home phone# (_____) ______________________ Cellular Ph# (____) _______________

Ok to leave detailed message? ______Yes _____No

E-mail address __________________________________

Employment Information

__Employed __Disabled __Unemployed __Retired __Self Employed __Student

Employer Name ____

Address _____________________________________ City ________________________

St______ Zip__________ Employer Ph# ____________________________ Ext. ___________

Pharmacy Information

Pharmacy Name _______________________________ Ph# (_____) ____________________

Pharmacy Address ____

City ______________________________ St _________________ Zip________________

Mail Order Pharmacy

Pharmacy Name ____________________________________ Ph# (_____) ________________

Pharmacy Address ____

City ______________________________ St _________________ Zip________________

Emergency Contact Information

Name ____________________________________ Relationship _____________________

Home Ph# (__) ________________ Cell Ph# (___) ______________________________

Insurance Information

Primary Insurance Carrier

Insurance Company . ____

Claims Address ___________________________ City ____________________

State _______ Zip _____ Customer Service Phone# (___) _________________

Insured Party's Name ________________________ Relationship to Patient ______

Insured Party's Date of Birth __________ Insured Party's SS# _________________

Insurance ID# ______________________ Group# ______________________

Secondary Insurance Carrier

Insurance Company ____

Claims Address ___________________________ City ____________________

State _______ Zip _____ Customer Service Phone# (__) _________________

Insured Party's Name ________________________ Relationship to Patient ______

Insured Party's Date of Birth, __________ Insured Party's SS# _________________

Insurance ID# ______________________ Group# ______________________

*********Assigned of Insurance Benefits*********

I hereby authorize direct payments of medical benefits to Diabetes & Endocrinology Center of Ohio, Inc for services rendered by them in person or under their supervision. I understand that by signing this form, I am financially responsible for payment of any balances due.

*********Consent to Treatment*********

I hereby authorize treatment by the physician and staff as they deem medically necessary for conditions they have diagnosed.

*******HIPAA Notification*******

I hereby acknowledge that Diabetes as Endocrinology Center of Ohio, Inc. has offered me a copy of the HIPAA Privacy Policy. I have ___accepted ___declined a copy.

______________________________ ____________________

Signature **Date**

Failure to complete all information may result in patient being billed directly for services.

Patient History Questionnaire

Patient Name ____ Date ______________________

Date of Birth ____________________ Marital Status _ S _M _D _W Occupation_________________

History of Present Illness- What are you being seen for?_____________________________________

Current Medication(s)
Please list all prescribed medications along with any over the counter or herbal medications

Medication	Strength / Dose	Times per day
______________________	____________________	___________________
______________________	____________________	___________________
______________________	____________________	___________________
______________________	____________________	___________________
______________________	____________________	___________________

(Please attach a separate sheet if additional space is needed.)

Allergies or Sensitivities to Medications (example: Penicillin- Rash)
__No Known Drug Allergies

Name of Medication	Reaction
________________________________	____________________________
________________________________	____________________________

Surgeries & Hospitalization
Please list all surgeries & hospitalizations

Hospitalization	Year	Reason	Surgery	Year
__ Y __ N	_____	________________	_________________	________
__ Y __ N	_____	________________	_________________	________
__ Y __ N	_____	________________	_________________	________
__ Y __ N	_____	________________	_________________	________

Social History

Do you currenty smoke?	__Yes __No	If yes, how many packs per day?_____
Do you drink alcohol?	__Yes __No	If yes, how often?_______________
Do you use street/recreational drugs?	__Yes __No	
Are you on a special diet?	__Yes __No	If yes, please explain._________________
Do you exercise?	__Yes __No	If yes, please explain. ________________

Patient & Family Medical History

Please indicate family history by marking Yes or No.
Please indicate any medical problems that you are being followed for under Patient Medical Problems'.

Patient Medical Conditions	Family Medical Conditions	
________________________________	Diabetes ___Type 1 ___Type 2	__Yes __No
________________________________	Thyroid Disorders	__Yes __No
________________________________	Pituitary Disorders/Tumors	__Yes __No
________________________________	Coronary Artery Disease	__Yes __No
________________________________	Congestive Heart Failure	__Yes __No
________________________________	Hypertension	__Yes __No
________________________________	High Cholesterol	__Yes __No
________________________________	Cancer/Type:_______________	__Yes __No
________________________________	Stroke	__Yes __No

Please list all current physicians. Please be sure to include as much information as possible to allow our physicians to communicate their findings.

Referring Physician

Name____________________________________ Practice Name_______________________________

Address ____________________________________ City _______________________ St_____ Zip _____

Phone# (____) _________________________ Fax# (____) ___________________________

Primary Care Physician

Name____________________________________ Practice Name_______________________________

Address ____________________________________ City _______________________ St _____ Zip ______

Phone# (____) _________________________ Fax# (___)_________________________

Additional Physicians

Name____________________________________ Practice Name_______________________________

Address ____________________________________ City _______________________ St Zip _____

Phone # (____)_______________________________ Fax# (_____)___________________________

Name____________________________________ Practice Name_______________________________

Address ____________________________________ City _______________________ St_____ Zip _____

Phone#(_____)_______________________________ Fax# (______)______________________________

I certify that the information given on this questionnaire is filled out to the best of my ability. I understand that the staff of DECO, Inc. will review my history with me at the initial exam.

_____________________________________ _________________________

Signature Date

Patient Name:___________________________________

Review of Systems

General
Loss of Appetite □ Yes □ No
Weight Loss □ Yes □ No
Weight Gain □ Yes □ No
Fatigue □ Yes □ No
Insomnia □ Yes □ No
Loss of Height □ Yes □ No

Endocrinology
Excessive Thirst □ Yes □ No
Excessive Urination □ Yes □ No
Sensitive to Cold □ Yes □ No
Sensitive to Heat □ Yes □ No
Breast Discharge □ Yes □ No
Breast Tenderness □ Yes □ No
Breast Growth (Men) □ Yes □ No

ENT
Voice Weakness □ Yes □ No
Persistent Hoarseness □ Yes □ No
Decreased Hearing □ Yes □ No
Poor Sense of Smell □ Yes □ No

Eye
Loss of Vision □ Yes □ No
Decreased Vision □ Yes □ No
Double Vision □ Yes □ No
Bulging Eyes □ Yes □ No
Dry Eyes □ Yes □ No

Hematology
Easy Bruising □ Yes □ No
Easy Bleeding □ Yes □ No

Cardiac
Chest Pain or Pressure □ Yes □ No
Palpitations □ Yes □ No
Leg Swelling □ Yes □ No
Leg Pain □ Yes □ No

Lungs
Shortness of Breath □ Yes □ No
Cough □ Yes □ No
Wheezing □ Yes □ No

Gastrointestinal
Nausea □ Yes □ No
Heartburn □ Yes □ No
Abdominal Pain □ Yes □ No
Bloating □ Yes □ No
Difficulty Swallowing □ Yes □ No
Vomiting □ Yes □ No
Diarrhea □ Yes □ No
Constipation □ Yes □ No

Neurologic
Frequent Headaches □ Yes □ No
Tingling in Hands/Feet □ Yes □ No
Tremor □ Yes □ No
Numbness □ Yes □ No
Migraines □ Yes □ No
Burning Pain in Feet □ Yes □ No
Burning Pain in Hands □ Yes □ No
Vertigo □ Yes □ No
Sciatica □ Yes □ No
Dizziness □ Yes □ No

Musculoskeletal
Joint Pain □ Yes □ No
Joint Stiffness □ Yes □ No
Back Pain □ Yes □ No
Fracture □ Yes □ No
Muscle Cramping □ Yes □ No
Weakness □ Yes □ No
Muscle Aches □ Yes □ No

Dermatology
Excessive Hair Growth □ Yes □ No
Excessive Dry Skin □ Yes □ No
Acne □ Yes □ No
Plantar Wart □ Yes □ No
Itching □ Yes □ No
Skin Ulcer □ Yes □ No
Vitiligo □ Yes □ No
Rashes □ Yes □ No

Allergy
Allergies □ Yes □ No
Sinus Congestion □ Yes □ No
Runny Nose □ Yes □ No
Itchy Eyes □ Yes □ No
Ear Fullness □ Yes □ No

Psychiatric
Depression □ Yes □ No
High Stress Level □ Yes □ No
Sleep Disturbances □ Yes □ No
Eating Disorders □ Yes □ No
Anxiety □ Yes □ No
Mood Swings □ Yes □ No

Urinary
Erectile Dysfunction (Men) □ Yes □ No
Urinating at Night □ Yes □ No
Difficulty Urinating □ Yes □ No

Gynecological (Women)
Breast Lumps or Discharge □ Yes □ No
Pregnant □ Yes □ No
Hot Flashes □ Yes □ No
Regular Periods □ Yes □ No
Menopause □ Yes □ No

Office Financial Policy

Insurance Information

As a courtesy to our patients, we will file claims to your primary and secondary insurance. Please note, your health insurance is a contract between you and your insurance company so it is your responsibility as the patient to make sure our physicians are covered under your plan. All insurance companies do not carry the same benefits so the services rendered to you in this office may or may not be covered. It is the patients' responsibility to know what is covered and if you need a referral.

1. A valid insurance card must be presented at each visit. If you do not have an insurance card with you it will be necessary to either reschedule the appointment or the patient can pay out of pocket at the time of the visit.
2. Copay is due at the time of service. If you do not have the copay amount your appointment may be rescheduled.
3. In order to successfully file a claim with your insurance company, you must provide all the requested information on the patient demographics form. This includes:
   A. subscriber's name
   B. subscriber's date of birth
   C. subscriber's social security number

No Show or Canceling of Appointments

We understand that emergencies may arise that prevent you from canceling your appointment in a timely manner (at least 24 hours notice). However, if you have 5 No Show/Late Cancel appointments within 1 year, you will be charged a $25.00 fee.

Self Pay Patients

All patients without insurance must pay for the visits at the time of service.

Statements

Mailed to the patient approximately every 30 days. A statement will be mailed to the patient once payment or further information regarding the visit has been received from your insurance company.

Payment Arrangements

Under special circumstances payment arrangements can be made with our billing office. If upon receipt of statement you are unable to pay the entire amount of your bill, a payment plan can be discussed. The following guidelines have been set in place to ensure proper and timely payment.

1. payment arrangements will not exceed 6 months from date of service, unless approved by the practice administrator
2. failure to uphold scheduled payments will result in a voided agreement and full payment will be due immediately
3. all payment agreements will officially be signed and dated

Any questions or concerns you may have can be addressed by our Practice Administrator Miranda, at 614-764-0707.

I have read and fully understand the above policy.

______________________________________ ____________________

Patient or Authorized Representative Signature Date

______________________________________ ____________________

DECO Representaive Signature Date