Diabetes & Endocrinology Associates, Inc.

100 Highland Avenue - Suite 203, Providence, RI 02906-2752
Tel: 401-351-7100 | Fax: 401-751-6179
diabendo@aol.com | www.diabendo.com

VALERIE A. THOMAS, M.D., ROBERT J. DOBRZYNSKI, JR., M.D., ROBERTO ORTIZ, M.D., MANCHIN CHANG, M.D., VORAWAN UMMARITCHOT, M.D.

Dear Patient,

Welcome to Diabetes & Endocrinology Associates, Inc. Your appointment is on_____ at_____. **PLEASE BRING THIS COMPLETED PACKET WITH YOU. DO NOT MAIL.** We have been in practice since 1974 as a private group and, in total, have averaged 100 years of endocrine and diabetic experience. Our physicians are consistently rated among "Rhode Island's Top Docs" by *Rhode Island Monthly Magazine.*

Here is a brief overview of office practices and procedures:

- Our five physicians are affiliated with Rhode Island and Miriam hospitals and consult at Fatima Hospital.
- Our office has a nurse educator, nutritionist and full-service laboratory.
- At the time of your visit, it is important that any laboratory, radiology and office notes are brought along.
- Physicians or their representatives will contact patients with laboratory and radiology results either by phone or mail. It is not necessary for patients to contact the office for results.
- Co-pays are required at the time of service.
- To transfer or obtain patients' records, it is required by law for a request to be made in writing and/or a signed medical release. A fee is also charged for this service.
- Office policy requires a 24-hour notice to cancel or reschedule an appointment. If a **new** patient fails to follow this policy, he/she will **not** be given another new patient appointment.
- It is our office policy that once you have become an established patient, you **cannot** transfer to another physician in the practice.

Office Hours:
Our office hours vary with individual physician from 7:30 a.m. to 4 p.m. In case of emergency, please dial 351-7100 then "9" for immediate assistance. For all other calls, please dial your physician's secretary directly.

- **Valerie A. Thomas, M.D. 490-5870**
- **Roberto Ortiz, M.D 490-5867**
- **Vorawan Ummaritchot, M.D. 490-5871**
- **Robert Dobrzynski, Jr., M.D. 490-5877**
- **Manchin Chang, M.D. 490-5872**

We look forward to taking part in your healthcare, and thank you in advance for your trust, cooperation, confidence and support in our office.

Sincerely,

Physicians and Staff of Diabetes and Endocrinology, Assoc., Inc.

DIABETES AND ENDOCRINOLOGY ASSOCIATES, INC.

DATE:_____

NAME_____ **ACCT#**_____

STREET ADDRESS_____

CITY & STATE_____ **ZIP**_____

HOME PHONE_____**CELL**_____**E-MAIL**_____

DATE OF BIRTH_____**SEX: M**____**F**____**SOC SEC#** _____

EMPLOYER NAME_____ **STREET ADDRESS**_____

CITY & STATE_____**ZIP**_____**PHONE**_____

SPOUSE'S NAME_____**SPOUSE'S SOC SEC#** _____

SPOUSE'S DATE OF BIRTH_____**SPOUSE'S CELL#**_____

SPOUSE'S EMPLOYER_____

STREET ADDRESS/PHONE#_____

PERSON TO NOTIFY IN AN EMERGENCY_____

RELATIONSHIP_____**PHONE**_____

CITY & STATE_____**ZIP**_____

REFERRING PHYSICIAN_____**PHONE**_____

ADDRESS OF PHYSICIAN_____**ZIP**_____

MEDICAL INSURANCE COMPANY_____

PHARMACY NAME AND PHONE#_____

MAY WE LEAVE A MESSAGE ON YOUR HOME OR CELL PHONE?_____

MAY WE E-MAILYOUR RESULTS TO YOU?_____

BILLING POLICIES

1. PAYMENT IS REQUESTED ON THE DAY OF SERVICE FOR ANY NON-COVERED SERVICES. THIS INCLUDES CO-PAYMENTS, OFFICE VISITS THAT ARE NOT COVERED BY YOUR INSURANCE CARRIER, ETC.

2. FOR PATIENTS WITH **MEDICARE AND PLAN 65**, ASSIGNMENT IS ACCEPTED BY THIS OFFICE. WE WILL ACCEPT THEIR PAYMENT AS PAYMENT IN FULL. IF YOU HAVE **MEDICARE WITH A COMMERCIAL SECONDARY PAYER**; (e.g. AARP), WE WILL FILE THE CLAIM FOR YOU IF THE CORRECT BILLING INFORMATION AND FORMS ARE PROVIDED. IF YOU HAVE **MEDICARE WITHOUT A SECONDARY INSURER**, YOU WILL BE BILLED FOR THE 20% CO-INSURANCE AND DEDUCTIBLE NOT COVERED BY MEDICARE.

3. **THE PATIENT IS RESPONSIBLE FOR OBTAINING A REFERRAL FROM THE PRIMARY CARE PHYSICIAN PRIOR TO BEING SEEN IF YOUR INSURANCE IS AN HMO,**

ASSIGNMENT OF BENEFITS AUTHORIZATION - PLEASE SIGN BELOW

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/INSURANCE BENEFITS BE MADE ON MY BEHALF TO DIABETES AND ENDOCRINOLOGY ASSOCIATES, INC. FOR ANY SERVICES PROVIDED TO ME BY DIABETES AND ENDOCRINOLOGY ASSOCIATES, INC. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

PATIENT OR LEGAL GUARDIAN SIGNATURE_____**DATE**_____

MEDICAL HISTORY
(*Please print)*

Patient Name_____**DOB**_____

1. Please state reason for your visit specifically_____

_____

2. If you reason involves an injury or injuries, please describe nature and give dates

_____

_____

_____

3. Are you currently under a doctor's care? Yes No

Doctor's Name_____Phone _____

Address_____

Second Doctor_____Phone _____

Address_____

4. <u>ALLERGIES or REACTIONS TO MEDICATIONS:</u>

When were your most recent IMMUNIZATIONS:

Influenza (Flu Shot)_____Pneumovax (Pneumonia) _____

Tetanus_____Varicella (chicken pox) shot _____

When were your most recent HEALTH MAINTENANCE screening tests

Lipid (Cholesterol Screening)_____Results? _____

Mammogram_____Results? _____

Ever abnormal?_____Details: _____

Pap Smear_____Results? _____

Ever abnormal?_____Details:_____

PSA (Prostate cancer screen) _____Results? _____

Stool test for blood_____Results? _____

Colonoscopy?_____Results? _____

MEDICAL HISTORY
(Continued - ***Please print)***

5. PERSONAL MEDICAL HISTORY:

Please indicate whether you have had any of the following medical problems (with dates):

_____Heart disease:

_____Bleeding/clotting problem

*specify type*_____

_____Blood transfusion

_____Heart attack

_____Cancer (Malignancy):

_____High blood pressure

*specify type*_____

_____Diabetes

_____High cholesterol

_____Stroke

_____Thyroid problem:

_____Depression/suicide attempt

*specify type*_____

_____Alcoholism

Other problems (specify)

_____

_____

6. Do you drink alcohol? Yes No Frequency/Amount _____

7. Tobacco use: Current: Yes No #pack(s) per day_____ #years _____

8. Any history of alcohol or drug dependency? Yes No

(please complete other side)

MEDICAL HISTORY
(Continued - *Please print)*

Patient Name_____DOB_____

List all previous surgeries or major illnesses along with appropriate dates _____

_____

_____

_____

9. Have you ever had a reaction to anesthetic including injectable anesthetic?----------Yes No

10. Do you have a history of increased bleeding tendency?----------Yes No

11. Have you ever had a blood transfusion?----------Yes No

12. Have you been treated for any mental or emotional disorders?----------Yes No

13. Do you have a history of scarring?----------Yes No

Where?_____

14. Family History:

Have any members of your family had the following:

Thyroid Disease Yes No _____

Allergies Yes No _____

Bleeding Problems Yes No _____

Cancer Yes No _____

Diabetes Yes No _____

Heart Disease Yes No _____

15. (For Women) is there ANY POSSIBILITY you are pregnant?----------Yes No

Last Menstrual Period_____

MEDICAL HISTORY
(Continued - *Please print)*

16. REVIEW OF SYMPTOMS: Please check (✓) any current problems you have on the list below:

Constitutional
___Fevers/chills/sweats
___Unexplained weight loss/gain
___Change in energy/weakness
___Excessive thirst or urination

Eyes
___Change in vision

Ears/Nose/Throat/Mouth
___Difficult hearing/ringing in ears
___Problems with teeth/gums
___Hay fever/allergies

Cardiovascular
___Chest pain/discomfort
___Palpitations

Chest (breast)
___Breast lump/nipple discharge

Respiratory
___Cough/wheeze
___Difficulty breathing

Gastrointestinal
___Abdominal pain
___Blood in bowel movement
___Nausea/vomiting/diarrhea
___*Genitourinary*
___Nighttime urination
___Leaking urine
___Unusual vaginal bleeding
___Discharge: penis or vagina

Musculo-skeletal
___Muscle/joint pain

Skin
___Rash/mole change

Neurological
___Headaches
___Dizziness/lightheadedness
___Numbness
___Memory loss
___Loss of coordination

Psychiatric
___Anxiety/stress
___Problems with sleep
___Depression
___*Blood/Lymphatic*
___Unexplained lumps
___Easy bruising/bleeding

Other
___Problems with sexual functio*n*

Signature of Patient, Parent or Guardian_____Date_____

Doctor Signature_____Date_____

PATIENT NAME:_____DATE:_____ACCT#_____

DIABETES & ENDOCRINOLOGY ASSOCIATES, INC.
MEDICATION LIST

Prescription medications	**Dose (Mg)**	**How Often Taken**

Medications or Drugs to which you are allergic

List all over-the-counter, vitamins/minerals, herb/natural medications

DIABETES & ENDOCRINOLOGY, ASSOCIATES, INC.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____acknowledge that I have received a copy of Diabetes & Endocrinology Associates, Inc's NOTICE OF PRIVACY PRACTICES. This notice describes how Diabetes & Endocrinology Associates, Inc. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____

(Signature of Patient or Personal Representative) Date

_____

(Relationship to Patient)

DIRECTIONS

PROVIDENCE OFFICE (Main Office)

100 Highland Avenue - Suite 203

Northbound:

95 North to Exit 24 (Branch Avenue). At the end of the exit, take a right on to Branch Avenue. Continue until you come to the light at the intersection of North Main Street and Branch Avenue (past Benny's). Take a left at the light onto North Main Street. Take right onto First Street (right after Shell gas station). We are the second brick building on the left. Park on the side of the building or across the street.

***Alternate*: Exit 25 (Smithfield) off 95 North. Follow signs to North Main Street. At light go up hill (Third Street) and turn right onto Highland Avenue.**

Southbound:

95 South to Branch Avenue exit. At the end of exit, take left onto Branch Avenue. Continue until you come to the light at the intersection of North Main Street and Branch Avenue (past Benny's). Take a left at the light onto North Main Street. Take right onto First Street (right after Shell gas station). We are the second brick building on the left. Park on the side of the building or across the street.

***Alternate*: Exit 25 (Smithfield) off 95 South. Turn left at exit and follow curved road to stop sign. Turn left and at light proceed straight up hill on Third Street. Turn right on Highland Avenue.**

WARWICK OFFICE: (Dr. Dobrzynski, Dr. Thomas, Dr. Ortiz, Dr. Chang one day per week) Warwick Medical Building, 400 Bald Hill Road, Lobby Floor

From 95 North take exit 12B. Bear right and follow signs to Warwick Mall. Warwick Medical Building is located in Warwick Mall parking lot.

From 95 South take left onto exit 11 (Route 295 North). Take exit 2 and follow signs to Warwick Mall. Warwick Medical Building is located in Warwick Mall parking lot.

LINCOLN OFFICE: (DR. THOMAS ONLY)

2 Wake Robin Road-Suite 205

95 North to 146 Lincoln/Woonsocket. Take right onto Route 116 Lincoln/Cumberland. At end of exit take a right. At traffic light take a left into Wendy's Plaza. The large building on the right is the George Washington Medical Center. Suite 205 is on the second floor.

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We at Diabetes and Endocrinology are beginning to use the electronic medical record to become compliant with the federal regulations. As part of this process, we need you to answer these questions to compete the data. Realize that you are allowed to answer “Patient refuses” as a choice and this will have no impact on your care. We, however, are required to ask.

Thank you for your time and patience as we transition to this new system!

Primary Language:

_____ English
_____ Spanish
_____ Portuguese
_____ Italian
_____ Chinese, dialect _____
_____ Russian
_____ Other _____
_____ Patient refuses to answer

Race:

_____ White
_____ American Indian or Alaskan native
_____ Asian
_____ Black or African American
_____ Native Hawaiian or other Pacific Island
_____ Patient refuses to answer

Ethnicity:

_____ Hispanic or Latino
_____ Not Hispanic or Latino
_____ Patient refuses to answer

Patient Signature: _____

Print Name: _____ Date of Birth: _____

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Dear Patient,

In order for us to comply with government standards for computerization and remain Medicare providers in good standings we are forced to obtain the following information for your record. Your help and understanding are greatly appreciated!

Please circle:

Are you a smoker: Never | Not Now | Yes | Quit Date: ___/___/_____

Number of years smoking: _____

Do you drink alcohol: Never | Rarely | Socially | Most Days | Daily

How much caffeine in a day: 0, one cup, two cups, three cups, 4+

Do you use any “street drugs”: Yes | No

Do you wear sun protection if in the sun: Yes | No

Do you have any tattoos: Yes | No

Are you a victim of Physical abuse: Yes | No

Are you the victim of Domestic abuse: Yes | No

Marital Status: Single | Married | Divorce | Widow/Widower

Do you wear seatbelts while in a car: Yes | No

Do you have any body piercings: Yes | No

Occupation: _____

Print Name: _____Date: _____

Date of Birth: _____