all worlds HEALTH

A compassionate, integrative approach to health

NEW PATIENT/CLIENT FORM (rev 5/3/16)

Patient's name: _____
(First) (Middle) (Last)

Date of birth: _____/_____/_____ Age: _____ Sex: _____ Preferred Name: _____
(Month) / (Day) / (Year)

Address: _____City:_____ State: _____ Zip: _____

Preferred phone # (circle: cell/ home/work): _____ Email: _____

Additional phone # (circle: cell/home/work): _____ Other phone: _____

Emergency contact, relationship & phone: _____

How did you hear about us? ☐Web ☐ Newspaper ☐ Other _____

☐ Friend/Family: _____

☐ Physician or Holistic Practitioner: _____

Do we have your permission to thank this person (or people) for the referral? ☐ Yes, that would be nice. ☐ No, I'd prefer not.

We need insurance information to help us order labs. Please provide a **copy of your insurance card** (front and back.)

Insurance Carrier: _____ State: _____

Preferred Laboratory? (circle): Quest Labs / Lab Corp

Preferred local pharmacy: _____

What is the purpose of your visit?

☐ Wellness: _____

☐ Ongoing problem (more than 3 months): _____

_____

_____

☐ New problem (less than 3 months) : _____

_____

Goals: _____

Primary care practitioner: _____

Other practitioners patient sees or has seen (eg, specialists, holistic practitioners, etc.): _____

_____

_____

PATIENT'S STORY... *A person's story is vital to health and wellbeing.*
Please fill out as much detail as you can in the following pages.

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

People and animals in household: _____

Occupation: _____ Ethnicity/cultural background: _____

Where did you grow up? _____ Do you have any children? ☐ No ☐ Yes _____

Highest level of education: ☐ 8th-12th grade ☐ High school ☐ Two-year/technical college ☐ College ☐ Graduate

Do you smoke? ☐No ☐ Yes _____ History of drug use? ☐ No ☐ Yes _____

How much and how often to you drink alcoholic beverages? _____

How much and how often to you drink caffeinated beverages? _____

Any military service? ☐No ☐ Yes, when and where? _____

Major life stressors: _____

Activities and interests: _____

A few words to describe your personality: _____

ENVIRONMENTAL HISTORY

Home built before 1978? ☐ No ☐ Yes ☐ Not sure

Have you tested your home for radon? ☐ No ☐ Yes ☐ Not sure

What is the source of your drinking water? ☐ Well water ☐ City water ☐ Bottled water

Have you been exposed to any toxic chemicals of which you are aware? ☐ No ☐ Yes ☐ Not sure

Do you often use solvents or other cleaning or disinfectant chemicals? ☐ No ☐ Yes ☐ Not sure

How often are pesticides applied inside or outside your home? _____

Does you watch TV, or use a computer or video game system more than two hours a day? ☐ No ☐ Yes

How many times a week to you spend time outdoors for at least 60 minutes? _____

Do you have any other questions or concerns about your home environment or symptoms that may be a result of your environment? ☐ No ☐ Yes

_____

MEDICAL HISTORY

Allergies (to Meds, Food, Environment): ☐ None known ☐ See attached page for list of allergies & details.

☐ YES, to _____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

Medications, Vitamins, Herbs, Supplements, Homeopathics, etc: ☐ None ☐ See attached page.

Name	Brand	Dose & Frequency

Year of Last Tetanus Immunization? _____

Any vaccine reactions? _____

Any major injuries? ☐ No ☐ Yes _____

Head injuries (eg., falls, concussions)? ☐ No ☐ Yes _____

Fractures? ☐No ☐ Yes _____

Hospitalizations? ☐ No ☐ Yes _____

Surgeries? ☐ No ☐ Yes _____

Birth History: Birth Place: _____ Birth Time (if known): _____

Any information regarding birth (normal, Cesarean, problems during pregnancy or birth, preterm)?

_____

Development: Any history of developmental issues (speech delay, motor delay, past therapies, learning issues)?

_____

What major TRAUMA have you had in your life, if any? _____

_____

STOOL pattern, appearance: _____

SLEEP pattern, length, quality, recurrent dreams: _____

ENERGY, note if sleepy in daytime and when:_____

SYMPTOM REVIEW: Please CIRCLE any symptoms you have had <u>OVER THE LAST YEAR</u>:

Neuro: (dizziness, headache, numbness/tingling, forgetfulness, tremors, brain fog)
Eyes: (blurry near, blurry far, seeing double or spots, glasses, contacts, dry, watery)
ENT: (difficulty hearing, ringing in ears, ear infection, sinus congestion, allergies)
Cardiovascular: (chest pain, high blood pressure, fainting)
Respiratory: (shortness of breath, wheezing, bronchitis)
Metabolic: (thyroid disorder, abnormal blood sugars, always hot or cold, weight loss, weight gain, fever)
GI: (cramping, heartburn, diarrhea, constipation)
GU: (frequent urination, urinary infections)
Skin/Hair: (rashes, itching, dryness, acne, dandruff, hair loss, excessive hair growth)

Musculoskeletal: (joint pain, muscle aches, back pain, neck pain)
Sexual function /libido: (low desire, trouble having orgasm)
Emotional/psychological health: (feeling stuck, feeling down, depression, mania)

MEN only : Prostate issues? ☐ NO ☐YES _____

WOMEN only: Menstrual Issues? ☐ NO ☐ YES _____

Have you ever been pregnant? ☐ NO ☐ YES: ___# pregnancies, ____#miscarriage, ____#abortions, _____# premie, ____ # children

Any pregnancy, birth, or fertility issues?_____

Please check the box next to any problems you or a family member has had (including parents, siblings, grandparents, aunts, uncles, and cousins):

	Patient	Relative	Comments
☐ Birth defects	☐	☐	_____
☐ Premature births	☐	☐	_____
☐ Ear infections	☐	☐	_____
☐ Hearing problems	☐	☐	_____
☐ Eye problems	☐	☐	_____
☐ Asthma	☐	☐	_____
☐ Allergies	☐	☐	_____
☐ Sinus/ nasal issues	☐	☐	_____
☐ Skin prob/rashes/ eczema	☐	☐	_____
☐ Pneumonia	☐	☐	_____
☐ Frequent sore throats	☐	☐	_____
☐ Heart problems	☐	☐	_____
☐ High blood pressure	☐	☐	_____
☐ High cholesterol	☐	☐	_____
☐ Chronic diarrhea	☐	☐	_____
☐ Chronic constipation	☐	☐	_____
☐ Chronic abdominal pain	☐	☐	_____
☐ Reflux/nausea/vomiting	☐	☐	_____
☐ Hepatitis	☐	☐	_____
☐ Urinary infections/GU prob	☐	☐	_____
☐ Kidney problems	☐	☐	_____
☐ Immune/Auto-immune prob	☐	☐	_____

	Patient	Relative	Comments
☐ Bleeding or Clotting prob	☐	☐	_____
☐ Cancer (list type)	☐	☐	_____
☐ Diabetes	☐	☐	_____
☐ Thyroid problems	☐	☐	_____
☐ Growth problems	☐	☐	_____
☐ Other endocrine/gland prob	☐	☐	_____
☐ Osteoporosis/Bone prob	☐	☐	_____
☐ Scoliosis	☐	☐	_____
☐ Arthritis/ joint issues	☐	☐	_____
☐ Chronic pain	☐	☐	_____
☐ Muscular problems	☐	☐	_____
☐ Swallowing issues	☐	☐	_____
☐ Coordination issues	☐	☐	_____
☐ Headaches	☐	☐	_____
☐ Seizures	☐	☐	_____
☐ Memory prob/Alzheimer's	☐	☐	_____
☐ Alcohol abuse	☐	☐	_____
☐ Substance abuse	☐	☐	_____
☐ School/learning issues	☐	☐	_____
☐ Depression/Mental illness	☐	☐	_____
☐ Socialization issues	☐	☐	_____
☐ Chromosomal issues	☐	☐	_____

History of other infections (eg., STDs, HIV, or other infections not listed above)?

☐ NO ☐ YES_____

History of physical or sexual abuse?

☐ NO ☐ YES_____

OTHER diagnoses or issues: _____

_____

DIETARY HISTORY:

Do you have any dietary preferences and why? Any foods avoided and why? _____

Typical breakfasts: _____

Typical lunches: _____

Typical dinners: _____

Typical snacks: _____

Drinks: _____

Any seafood? ☐ No ☐ Yes (Kinds, how often)_____

What kinds of oils do you use? _____

Foods preferences: ☐ Salty ☐ Sweet ☐ Crunchy ☐ Creamy ☐ Other_____

Foods avoided and why:_____

_____

What kinds of food do you buy (check all that appy)? ☐ Grocery ☐ Local ☐ Organic ☐ Restaurant

Veggies ☐ most meals ☐ daily ☐ 3x/week ☐ weekly

Fruits ☐ everyday ☐ 3x/week ☐ weekly

How would you describe your relationship to food? _____

Any concerns regarding your diet/nutrition/supplements? _____

_____

SOUL

When do you feel your best? _____

What gets you down? _____

How would you describe your spirituality? _____

Anything else I should know? _____

_____

_____

_____

_____

_____

Some notes before your visit:
Please…

- **Bring your supplements to your appointments.**
- **Bring in copies of labs in the last year as well as ANY genetic testing (or email them to welcome@allworldshealth.com).**
- **Avoid wearing any perfumes or fragrances when coming to the office as we have many patients with sensitivities.**
- **Add our email welcome@allworldshealth.com to your contacts so you don't miss any important messages.**

Our office address is 800 Old Roswell Lakes Pkwy, Suite 310, Roswell GA 30076. It's in Old Roswell Lakes office complex, which is just one block north of Holcomb Bridge and one block east of Alpharetta St/Hwy 19. After entering the office complex, we are the SECOND BUILDING ON THE RIGHT, and on the TOP FLOOR. Thank you! We look forward to seeing you soon.

I. Consent for Treatment
II. HIPAA Policy
III. Fax/Email Authorization
IV. Medicare/Medi-Gap Opt-Out
V. Office Policies
VI. Credit Card on File Authorization

I. Consent for Treatment

The undersigned, do hereby agree and give my consent for All Worlds Health, Arlene Dijamco, MD, and any other practitioner associated with the practice to furnish all treatment and medical care considered necessary.

✎ _____ _____

Patient or Legal Guardian **Date**

II. Acknowledgement of All Worlds Health HIPAA Policy

I have reviewed All Worlds Pediatrics HIPAA privacy policy which is summarized as follows:

a. Right to access/copy private health information (PHI)
b. Right to amend PHI
c. Right to restrict use or disclosure
d. Right to confidential communications
e. Right to an accounting of disclosures
f. Right to file a complaint

I am aware that the complete HIPAA policy for All Worlds Pediatrics may also be accessed on the internet at allworldshealth.com.

✎ _____ _____

Patient or Legal Guardian **Date**

III. Fax / Email / Text Authorization

I hereby authorize and direct Arlene Dijamco, MD, FAAP and any other practitioner or office staff at All Worlds Pediatrics and All Worlds Health to send all or part of the patient's medical records, lab results, consultation notes, and other Protected Health Information to me via fax, email, or text.

I acknowledge the following:

- I have the right to revoke this authorization at any time by sending written notification to you. I understand that the revocation of this authorization is not effective to the extent that you have relied upon it by sending the Protected Health Information prior to receiving my written revocation notice.
- I understand that any Protected Health Information forwarded to me pursuant to this Authorization may be subject to unauthorized interception and is no longer protected under HIPAA.
- I acknowledge that Arlene Dijamco, MD, FAAP and all other practitioners at All Worlds Pediatrics (aka All Worlds Health) will not condition the patient's care or treatment on whether I sign this Authorization.

✎ _____ _____

Patient or Legal Guardian **Date**

IV. Medicare / Medi-Gap Opt-Out

Arlene L. Dijamco, MD
NPI # 1649245374
Pediatrics, Integrative Medicine and Osteopathy
All Worlds Health
800 Old Roswell lakes Pkwy, Suite 310, Roswell, GA 30076
678-629-3988 | allworldshealth.com

I, _____, agree to be personally, financially liable for all charges, without any limits that would be imposed, for all Medicare covered services provided by Dr. Arlene Dijamco from the date of this contract onward.

I agree that I, or anyone on my behalf, will NOT submit a claim to Medicare or Medigap or ask my physician to bill Medicare or Medigap Insurance. I am aware that other supplemental plans may elect not to make payments for services not paid for by Medicare.

I understand that Medicare payment will not be made for Medicare services that otherwise would have been paid by Medicare.

I understand that I retain the right to receive services from physicians and practitioners for whom Medicare coverage and payment would be available.

I understand that full payment is due upon completion of my visit.

Furthermore, I am currently not facing an emergency or urgent health situation.

✎ Signed: _____ Date: _____
Patient (Medicare Beneficiary or Legal Representative)

I, Arlene L. Dijamco, MD acknowledge this contract and further state that I have not been excluded from Medicare.

Signed: _____, MD Date: _____
Arlene Dijamco, MD

V. OFFICE POLICIES for All Worlds Health

- **Cancellation Policy:** Visits are by appointment only. We frequently book out in advance and keep a wait-list for those who would like to be seen sooner. In order to provide the best care and be most accessible to patients in need, please cancel or reschedule as soon as you find you are unable to keep your appointment. We understand that life can be unpredictable and also appreciate your consideration.
    - I understand that if I cancel a **new-patient** appointment with less than **TWO FULL BUSINESS DAYS**, AWH reserves the right to charge a cancellation fee equal to 50% of the visit fee.
    - I understand that if I cancel a **follow-up** appointment with less than **24 hours notice**, AWH reserves the right to charge a $50 cancellation fee.
    - I understand that if I "**no-show**" for any appointment, AWH reserves the right to charge a "no-show" fee equal to 50% of the visit fee.

Initial: _____

- **Billing:**
    - The initial appointment with **Dr. Dijamco** is $375 for 55 minutes; infants under 12 months of age have a special introductory rate of $325. For follow-up appointments, Dr. Dijamco's billing rate is $200 for 25 minutes and $40 for each additional 5-minute increment.
    - Please note that rates for any practitioners (including those not listed above) may vary and be subject to change. All current rates will be posted on the website.
    - Payment will be made at time of service. Any account not paid under agreement will be considered in default and will be referred for proper collection. All expenses incurred from such action shall be the responsibility of the patient/responsible party including, but not limited to, collection charges, legal fees, etc.

Initial: _____

- **Phone consultation policy:** Phone consultations require our full attention. Phone consultations will be billed at the same rate in 5-minute intervals ($40/5 minutes for Dr. Dijamco).

Initial: _____

- **Insurance:** As a courtesy upon request, we will provide a basic coding sheet to help you submit your bill to your insurance company for reimbursement, should you choose to do so. This is an option ONLY if you have a PPO, Health Savings Account, or Flex Spending Account. We do not provide coding sheets to those with Medicare or HMOs. If you do not need a coding sheet, please let us know so that we may reduce our paperwork. Please keep in mind that if the insurance company requires extensive paperwork for our staff, we may need to charge an administrative fee. (Typically, administrative fees start at $50.)

Initial: _____

- **Lab Results Policy:** For your safety, lab results are ONLY released during a follow-up appointment so that the results may be discussed with you fully.

Initial: _____

- **Administrative Fees:** At times, you may request either Dr. Dijamco to fill out paperwork on your behalf. The usual hourly rates will apply in 5-minute intervals ($40/5 minutes for Dr. Dijamco)

Initial: _____

- **All Worlds Health is a specialty practice, providing consultations for integrative health and cranial osteopathic care. We encourage and expect all patients to maintain a relationship with their local general pediatrician, family practitioner, and/or internist. We believe that a collaborative approach provides the best care for you and your family.**

Initial: _____

VI. Credit Card on File Authorization

Please complete this form for All Worlds Health & Pediatrics, P.C. to keep your credit card on file for late-cancellation/ no-show fees. For your convenience, we can also charge virtual consultation fees or phone orders on this card as well.

For in-person visits, we typically request that you use your physical card (or Apple Pay) to process transactions to minimize virtual payments. However, there are times we may request to use your card on file (eg, due to staffing or pandemic precautions).

Information to be completed by the card holder:

Cardholder Name: _____

Card Number: _____

Card Type: Visa MasterCard American Express

Expiration Date: _____

Security Code: _____ (3 digit code on back, except AMEX 4 digits on front)

Billing Zip Code: _____

E-mail for invoices/receipts: _____

I, _____, authorize ***All Worlds Health*** to charge the above credit card account for payments owed to my account for services rendered at their office. I agree to update any information regarding this account. The above information is complete and correct to the best of my knowledge.

Cardholder Signature _____ Date: _____