



NEW PATIENT 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: _____

Mother's full name: _____ Mother's date of birth: _____

Father's full name: _____ Father's date of birth: _____

Legal guardian (if different from above. Please provide a copy of legal documentation.): _____

Emergency contact, relationship & phone: _____

How did you hear about us? Web Newspaper Other _____

Friend/Family: _____

Physician or other Practitioner: _____

We need insurance information to help us order labs. Please provide a **copy of your insurance card**.

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: _____

Patient's 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.*

SOCIAL HISTORY

Names of siblings None

Date of birth

_____	_____
_____	_____
_____	_____

People and animals in household: _____

Parent's marital status: Single Married Separated Divorced Widowed

Mother's occupation: _____ Father's occupation: _____

Patient's ethnicity/cultural background: _____

School/daycare: _____ Grade: _____

Activities and interests: _____

A few words to describe this patient's 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 Filtered, Type: _____

Is your child 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 your child watch TV, or use a computer or video game system more than two hours a day? No Yes

How many times a week does your child have unstructured, free play outside for at least 60 minutes? _____

Do you have any other questions or concerns about your child's home environment or symptoms that may be a result of his or her environment? No Yes

MEDICAL HISTORY

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

<input type="checkbox"/> YES, to _____	Reaction: _____
_____	Reaction: _____
_____	Reaction: _____
_____	Reaction: _____
_____	Reaction: _____
_____	Reaction: _____
_____	Reaction: _____
_____	Reaction: _____
_____	Reaction: _____

Medications, Vitamins, Herbs, Supplements, Homeopathics, etc: None See attached

Name	Brand	Dose & Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Immunizations Up-to-Date? Yes No, because _____

Any reactions? _____

Vaccine record attached Vaccine record is available via the Georgia Registry (GRITS).

Any major injuries? No Yes _____

Suture/ Stitches No Yes _____

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

Fractures? No Yes _____

Hospitalizations? No Yes _____

Surgeries? No Yes _____

Pregnancy: Mom's general health during pregnancy: _____

Father's general health during pregnancy: _____

For the mother during pregnancy:

Medications: _____

Hospitalizations: _____

Injuries: _____

Illness: _____

Change in home environment (moved, job change, marital status change): _____

Birth: Birth Place (City & Hospital): _____ Birth Time (if known): _____

Mother's age at birth: _____ Father's age at birth: _____

Premature: _____ wks Full term: _____ wks Post-term: _____ wks

Birth weight: _____ Bruising/Molding: No Yes

Cesarean? No Yes, because _____

Forceps or suction? No Yes _____

Baby's presentation (circle): Regular Breech Face-up Other: _____

Complications with baby? No Yes _____

Complications with mother (physical/mental or emotional)? No Yes _____

Other information regarding birth story? _____

Torticollis? No Yes (left/ right) Blocked tear duct? No Yes (left/ right)

Breastfed? No Yes, until _____ Pacifier? No Yes, until _____

Formula? No Yes, type: _____

Any early formula or food intolerances? No Yes _____

Development: Crawled before walking? No Yes Age walked: _____

First words at approximately _____ months

Any therapies? No Yes _____

Any developmental concerns? _____

What kinds of major life trauma has your child had, if any? _____

STOOL pattern, appearance, etc: _____

SLEEP pattern, length, quality, dreams: _____

ENERGY level: _____

Please check the box next to any problems this patient or relative (including parents, siblings, grandparents, aunts, uncles, and cousins) have had:

	Patient	Relative	Comments		Patient	Relative	Comments
<input type="checkbox"/> Birth defects	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Premature births	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Ear infections	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Growth problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Other endocrine/gland prob	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Eye problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Growing pains/ bone issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Neck or back pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Sinus/ nasal problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Arthritis/ joint issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Skin issues/ rashes/eczema	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Muscular problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Frequent sore throats	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Swallowing issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Coordination issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Sudden/unexplained death	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Memory problems/Alzheim	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Chronic diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Chronic constipation	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Chronic abdominal	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> School problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Reflux/nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Sensory issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Learning problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Urinary infections or other GU issues	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Depression/ mental illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Behavioral issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Anemia/ blood prob	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Communication issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Immune/Auto-immune prob	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Socialization issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Chromosomal issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
				<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	_____
				<input type="checkbox"/> Physical/Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 apply)? 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

What is special about this patient? _____

When does this patient feel their best? _____

What gets this patient down? _____

How would you describe this patient's spirituality? _____

Anything else about this patient we 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. Office Policies
V. 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.



Parent 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.



Parent 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 Health & Pediatrics, P.C., 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, P.C., (aka All Worlds Health) will not condition the patient's care or treatment on whether I sign this Authorization.



Parent or Legal Guardian

Date

IV. OFFICE POLICIES for All Worlds Health & Pediatrics, P.C. (AWHP)

- **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 paper work. 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: _____

V. 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: _____