



**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.

YES, to \_\_\_\_\_ 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](mailto:welcomed@allworldshealth.com)).**

**⌘ Avoid wearing any perfumes or fragrances when coming to the office as we have many patients with sensitivities.**

**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](http://allworldshealth.com).

 \_\_\_\_\_  
Parent or Legal Guardian Date

**III. Fax / Email 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 email or fax.

**I acknowledge the following:**

- o 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.
- o 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.
- o 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 \$300 for 55 minutes; infants under 12 months of age have a special introductory rate of \$200. For follow-up appointments, Dr. Dijamco’s billing rate is \$160 for 25 minutes and \$32 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 (\$32/5 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 \$30.)

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 (\$32/5 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 information on file for cancellation/no-show fees. For your convenience, we can also charge visit fees on this card if you would prefer.

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 & Pediatrics, P.C.** 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: \_\_\_\_\_