all worlds HEALTH & PEDIATRICS
A compassionate, integrative approach to health

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: _______________
_______________ 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
☐ Birth defects	☐	☐	____________
☐ Premature births	☐	☐	____________
☐ Ear infections	☐	☐	____________
☐ Hearing problems	☐	☐	____________
☐ Eye problems	☐	☐	____________
☐ Asthma	☐	☐	____________
☐ Allergies	☐	☐	____________
☐ Sinus/ nasal problems	☐	☐	____________
☐ Skin issues/ rashes/eczema	☐	☐	____________
☐ Pneumonia	☐	☐	____________
☐ Frequent sore throats	☐	☐	____________
☐ Heart problems	☐	☐	____________
☐ High blood pressure	☐	☐	____________
☐ Sudden/unexplained death	☐	☐	____________
☐ High cholesterol	☐	☐	____________
☐ Chronic diarrhea	☐	☐	____________
☐ Chronic constipation	☐	☐	____________
☐ Chronic abdominal	☐	☐	____________
☐ Reflux/nausea/vomiting	☐	☐	____________
☐ Hepatitis	☐	☐	____________
☐ Urinary infections or other GU issues	☐	☐	____________
☐ Kidney problems	☐	☐	____________
☐ Anemia/ blood prob	☐	☐	____________
☐ Immune/Auto-immune prob	☐	☐	____________
☐ Cancer	☐	☐	____________

	Patient	Relative	Comments
☐ Diabetes	☐	☐	____________
☐ Thyroid problems	☐	☐	____________
☐ Growth problems	☐	☐	____________
☐ Other endocrine/gland prob	☐	☐	____________
☐ Growing pains/ bone issues	☐	☐	____________
☐ Scoliosis	☐	☐	____________
☐ Neck or back pain	☐	☐	____________
☐ Arthritis/ joint issues	☐	☐	____________
☐ Chronic pain	☐	☐	____________
☐ Muscular problems	☐	☐	____________
☐ Swallowing issues	☐	☐	____________
☐ Coordination issues	☐	☐	____________
☐ Headaches	☐	☐	____________
☐ Seizures	☐	☐	____________
☐ Memory problems/Alzheim	☐	☐	____________
☐ Alcohol abuse	☐	☐	____________
☐ Substance abuse	☐	☐	____________
☐ School problems	☐	☐	____________
☐ Sensory issues	☐	☐	____________
☐ Learning problems	☐	☐	____________
☐ Depression/ mental illness	☐	☐	____________
☐ Behavioral issues	☐	☐	____________
☐ Communication issues	☐	☐	____________
☐ Socialization issues	☐	☐	____________
☐ Chromosomal issues	☐	☐	____________
☐ AIDS/HIV	☐	☐	____________
☐ Physical/Sexual Abuse	☐	☐	____________

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

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 <u>labs</u> 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 $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: _______________