

Patient Forms

Instructions for Filling These Forms

If you have a recent version of the free Adobe Reader, you can use its "Typewriter" tool to fill in this form. You can download the free Reader [here](#).

1. Open this document in Adobe Reader.
2. From the menu of Reader 10 (your version may vary) click **Tools**.
3. Click **Add or Edit Text Box**.
4. The Typewriter toolbar opens. Click where you want to add text and begin typing.
5. When done, print the form, sign it where necessary, and bring it in on your first appointment.

Warren M Levin, MD, PLLC
The Blending of Conventional and Alternative Philosophies
407 Church Street NE, Suite E
Vienna, Virginia 22180
Office: (703) 255-0313 Fax: (703) 255-0316
info@WarrenMLevinMD.org

ACKNOWLEDGEMENT

I have read the welcome packet and understand its content. Specifically, I understand that Dr. Levin does not participate, bill, or provide health insurance services including Medicare Part B. He does not provide emergency medical services, home, or critical/crisis care and is not affiliated with any hospital with regards to admissions.

NAM E : _____ **DATE OF BIRTH :** _____
SIGNATURE : _____
RELATIONSHIP TO PROSPECTIVE PATIENT : _____
TODAY'S DATE : _____

As a reminder, the maintenance of health requires discipline, moderation, and maturity. The resolution of disease also requires vigilance and patience. We look forward to meeting with you!

Warren M Levin, MD
FAAFP (retired), FACN, FAAEM

**A PHOTOCOPY OF THIS AGREEMENT WILL BE CONSIDERED AS EFFECTIVE
AND VALID AS THE ORIGINAL .**

*Please note that fees are subject to change without notice

W arren M Levin, M D, PLLC
The B lending of C onventional and A lternative Philosophies
407 C hurch S treet N E , S uite E
V ienna, V irgin ia 22180
O ffice: (703) 255-0313 Fax: (703) 255-0316
[info@ W .arrenM .LevinM .D.org](mailto:info@W.arrenM.LevinM.D.org)

U R G E N T R E Q U E S T F O R R E L E A S E O F M E D I C A L R E C O R D S

Dear Prospective Patient,

Please fill out this form, sign it, and forward it to your treating physician(s) and/or to the hospital(s) where you were treated. Please do this as soon as possible to insure that your records are forwarded to Dr. Warren M Levin prior to your appointment.

DEAR HOSPITAL/PHYSICIAN:

PLEASE RELEASE AND FORWARD A COPY OF MY MEDICAL RECORDS AS SOON AS POSSIBLE TO:

W arren M L evin, M D
407 C hurch S treet N E , S uite E
V ienna, V irgin ia 22180
O ffice: (703) 255-0313 Fax: (703) 255-0316

I hereby give my permission to release my medical records to Dr. Warren M Levin. Thank you!

[Print]: Name _____
Address _____
City _____ State _____ Zip _____
Social Security # _____ Date of Birth _____
Signature _____ Date _____

Warren M Levin, M.D., PLLC

The Blending of Conventional and Alternative Philosophies

407 Church Street NE, Suite E

Vienna, Virginia 22180

Office: (703) 255-0313 Fax: (703) 255-0316

info@WarrenMLevinMD.org

Pharmacy Form: _____ DOB: _____
Last Name, First Name mm/dd/yyyy

Please list information for the pharmacies which you use most frequently for your prescriptions. Please advise us to which pharmacy you wish to have a new prescription or refill faxed. If the pharmacies have the same name, you must advise Pharmacy A, B, or C. Should you change pharmacies, please update this form (available at our front desk or from our website under "New Patient Form").

A)
Pharmacy Name _____
Address _____
City _____ State _____
Phone (____) _____ Fax (____) _____

B)
Pharmacy Name _____
Address _____
City _____ State _____
Phone (____) _____ Fax (____) _____

C)
Pharmacy Name _____
Address _____
City _____ State _____
Phone (____) _____ Fax (____) _____

Warren M Levin, MD, PLLC

PLEASE PRINT

PATIENT INFORMATION					
NAME: LAST FIRST MIDDLE			DRIVER'S LICENSE:		
			STATE: #:		
SEX: M F	DATE OF BIRTH:	AGE:	MARITAL STATUS: S M W D	SOCIAL SECURITY NUMBER:	HOME PHONE #: ()
ADDRESS: STREET CITY STATE ZIP				CELL PHONE #: ()	
CITY OR COUNTY OF RESIDENCE (SPECIFY):				FAX #: ()	
ARE YOU: EMPLOYED OUT OF WORK/RETIRED FULLTIME/PARTTIME STUDENT			OCCUPATION:		WORK PHONE #: ()
EMPLOYER'S ADDRESS: STREET CITY STATE ZIP					
REFERRED BY:		FAMILY DOCTOR'S NAME:		FAMILY DOCTOR'S PHONE #:	
EMERGENCY CONTACT:		RELATIONSHIP TO PATIENT:		PHONE #: ()	

CREDIT CARD PAYMENT AUTHORIZATION

I, _____ hereby authorize Warren M Levin, MD and/or the staff at 407 Church Street NE, Suite E, Vienna, Virginia 22180 to charge my credit card for services rendered and/or products supplied for a period of one year from the date below. It is my responsibility to notify Warren M Levin, MD of any changes regarding the card authorization.

NAME: (as it appears on credit card): _____

MasterCard Visa American Express Discover

Credit Card Number: _____ Expiration: _____ Security Code: _____

Signature: _____ Date: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

PERSON FINANCIALLY RESPONSIBLE (IF DIFFERENT FROM ABOVE)

NAME:	PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY: CHILD SPOUSE OTHER	OCCUPATION:
ADDRESS: STREET	SOCIAL SECURITY #:	HOME PHONE #: ()
CITY STATE ZIP	EMPLOYER'S NAME:	EMPLOYER'S PHONE #: ()

SIGNATURE: _____ **DATE:** _____
(AUTHORIZED PERSON)

[qwt'go ck"aa

Warren M Levin, M.D., PLLC

The Blending of Conventional and Alternative Philosophies

407 Church Street NE, Suite E

Vienna, Virginia 22180

Office: (703) 255-0313 Fax: (703) 255-0316

info@WarrenMLevinMD.org

Patients that have been previously diagnosed with Lyme Disease and/or other tick-borne diseases, we ask that you complete this form and bring it to your first office visit.

I, _____, have been previously diagnosed by

Dr. _____ of (City, State) _____ with:

___ Lyme disease

___ Amebiasis

___ Ehrlichiosis

___ Giardiasis

___ Rocky Mountain spotted fever

___ Other (specify) _____

on or about (month and year) _____.

Patient Signature: _____ Date of Birth: _____

Patient Address: _____

City, State, Zip Code: _____

City or County of Residence (specify): _____

Date: _____

Warren M. Levin, M.D., PLLC
The Blending of Conventional and Alternative Philosophies
407 Church Street NE, Suite E
Vienna, Virginia 22180
Office: (703) 255-0313 Fax: (703) 255-0316
info@WarrenMLevinMD.org

INSTRUCTIONS FOR VISUAL CONTRAST SENSITIVITY TEST

“THE VCS TEST”

1. On a computer with a clear, bright screen, go to www.ChronicNeurotoxins.com
2. At the upper left of the screen click on “register” and fill out the form. At the end it asks you for a “user id” and “password” – you choose your own and be sure to memorize it or write it down for future use.
3. Now you must “log in”, using that “user id” and “password” (button at upper left).
4. Click on “purchase vision test” – also on upper left. Choose one of the options. If you are sure you have Lyme Disease, purchase at least 3 tests.
5. Click on Preliminary Test and complete Parts A and B. Wait for confirmation of payment by e-mail (approximately one day) before attempting to take the VCS vision test.
6. After receiving e-mail confirmation, click “Take Vision Tests”. You should be 18” (eighteen inches) from the screen and wearing glasses, if needed, to have the best possible vision.
7. Follow the instructions on the screen. If you can read them easily, your vision is OK.
8. Somewhere during this process you will be asked if you want your physician to get a copy of the results. Please say “yes” and provide Dr. Levin’s E-mail: info@WarrenMLevinMD.org
9. When you have completed the VCS test, you will immediately be given a report – it is either “positive”, “negative”, or “equivocal”.
10. You will then be given the opportunity to “view details”. Please be sure you look at both the preliminary tests and the *graph* of the VCS test.
PLEASE PRINT OUT TWO COPIES OF THE PRELIMINARY TESTS AND THE GRAPH OF THE VCS TEST – ONE FOR YOU, AND ONE FOR DR. LEVIN.
11. Bring or send or fax one copy to Dr. Levin, just in case the E-mail doesn’t work.
12. The info on the website is fascinating, and if your VCS graph is “positive” you should take the opportunity to learn about it!

Patient Name: _____

Date: _____

THYROID SYMPTOM SURVEY

INSTRUCTIONS: Grade your symptoms according to the following:

Idon't have this.	Mild.	Moderate.	Severe.
0	1	2	3

HYPOTHYROID SYMPTOMS

- _____ 1. More tired and sluggish than normal
- _____ 2. Drier skin or hair than normal
- _____ 3. Sleep more than usual
- _____ 4. Weaker muscles
- _____ 5. Colder than others
- _____ 6. Muscles cramp more than usual
- _____ 7. Poorer memory
- _____ 8. More depressed
- _____ 9. Slower thinking
- _____ 10. Eyes are puffier
- _____ 11. Math is more difficult
- _____ 12. Hoarser or deeper voice
- _____ 13. Constipated more often
- _____ 14. Coarser hair
- _____ 15. Puffy hands and feet
- _____ 16. Unsteady gait
- _____ 17. Gain weight easily
- _____ 18. Outer third of eyebrows thin
- The next 2 questions apply to Menstruating Females Only*
- _____ 19. Menses more irregular
- _____ 20. Heavier menses

_____ **Total**

HYPERTHYROID SYMPTOMS

- _____ 1. Tachycardia (fast pulse, heart racing)
- _____ 2. Palpitations (Skipping of pulse of heart)
- _____ 3. Insomnia (can't sleep)
- _____ 4. Shakiness (tremors)
- _____ 5. Increased sweating
- _____ 6. Brittle nails
- _____ 7. Loss of appetite

_____ **Total**

Warren M Levin, M.D., PLLC

The Blending of Conventional and Alternative Philosophies

407 Church Street NE, Suite E

Vienna, Virginia 22180

Office: (703) 255-0313 Fax: (703) 255-0316

Name: _____ Today's Date: _____

Have you had any of the following in relation to this illness? (CIRCLE "NO" OR "YES")

Tick bite- N Y "EM" rash (discrete circle)- N Y ACA rash- N Y

Spotted rash over large area- N Y Linear, red streaks- N Y

SYMPTOM OR SIGN	CURRENT SEVERITY				CURRENT FREQUENCY				
	NONE	MILD	MODERATE	SEVERE	NA	NEVER	OCCASIONAL	OFTEN	CONSTANT
Persistent swollen glands									
Sore throat									
Fevers									
Sore soles, especially in the AM									
Joint pain									
Fingers, toes									
Ankles, wrists									
Knees, elbows									
Hips, shoulders									
Joint swelling									
Fingers, toes									
Ankles, wrists									
Knees, elbows									
Hips, shoulders									
Unexplained back pain									
Stiffness of the joints or back									
Muscle pain or cramps									
Obvious muscle weakness									
Twitching of the face or other muscles									
Confusion, difficulty thinking									
Difficulty with concentration, reading, problem absorbing new information									
Word search, name block									
Forgetfulness, poor short term memory, poor attention									
Disorientation: getting lost, going to wrong places									
Speech errors- wrong word, misspeaking									
Mood swings, irritability, depression									
Anxiety, panic attacks									
Psychosis (hallucinations, delusions, paranoia, bipolar)									
Tremor									
Seizures									
Headache									
Light sensitivity									
Sound sensitivity									
Vision: double, blurry, floaters									
Dental pain									

Name: _____ Today's Date: _____

SYMPTOM OR SIGN	CURRENT SEVERITY				FREQUENCY				
	NONE	MILD	MODERATE	SEVERE	NA	NEVER	OCCASIONAL	OFTEN	CONSTANT
Hearing: buzzing, ringing, decreased hearing									
Increased motion sickness, vertigo, spinning									
Off balance, "tipsy" feeling									
Lightheadedness, wooziness, unavoidable need to sit or lie									
Tingling, numbness, burning or stabbing sensations, shooting pains, skin hypersensitivity									
Facial paralysis-Bell's Palsy									
Neck creaks and cracks, stiffness, neck pain									
Fatigue, tired, poor stamina									
Insomnia, fractionated sleep, early awakening									
Excessive night time sleep									
Napping during the day									
Excessive daytime sleepiness									
Unexplained weight gain									
Unexplained weight loss									
Unexplained hair loss									
Pain in genital area									
Unexplained menstrual irregularity									
Unexplained milk production; breast pain									
Irritable bladder or bladder dysfunction									
Erectile dysfunction									
Loss of libido									
Queasy stomach or nausea									
Heartburn, stomach pain									
Constipation									
Diarrhea									
Low abdominal pain, cramps									
Heart murmur or valve prolapse?									
Heart palpitations, pulse skips									
"Heart block" on EKG									
Chest wall pain or ribs sore									
Head congestion									
Breathlessness, "air hunger", unexplained chronic cough									
Night sweats									
Exaggerated symptoms or worse hangover from alcohol									
Symptom flares every four weeks									
Degree of disability									

Warren M Levin, M.D., PLLC
Confidential Patient Health History

Patient Name: _____ Date of Birth: _____ Date: _____
What is your primary complaint today? _____

How long have you had this condition? _____ How long has it been since you really felt good? _____
Please list any previous diagnoses and treatments received for this condition. _____

Allergies – please list and include any known allergies to any medications, supplements, foods and environments. Attach additional sheet if needed. **Check here if none**

<u>Substance</u>	<u>Reaction</u>
_____	_____
_____	_____
_____	_____
_____	_____

Past Medical History and Review of Symptoms – Please check if you have had or presently experiencing any of the following (Please check one):

****C – Current P – Past**

C	P		C	P		C	P		C	P		C	P	
		High blood pressure			Bronchitis			Heart disease			Arthritis			Tuberculosis
		Head or neck radiation			Abdominal discomfort			Unexplained weight gain/loss			Low back problems			Hepatitis or jaundice
		Change in bowel habits			Diabetes			Asthma			Skin disease			Ulcers
		Kidney disease			Palpitations			Nausea			Blood disorders			Colitis
		Chest pain/tightness			Hay fever			Difficulty urinating			Venereal disease			Headache
		Shortness of breath			Indigestion			Constipation			Anxiety			Blood in stool
		Frequent urination			Cancer			Swollen ankles			Depression			Kidney stones
		Gall bladder disease			Gout			Thyroid disease			Anemia			Hemorrhoids
		Lightheadedness			Vomiting			Pneumonia			Alcohol abuse			
		Persistent cough			Drug abuse			Rheumatic fever			Diarrhea			

Women ONLY: Gynecological and Obstetric History:

Age at onset of periods: _____ Frequency: _____ Length of Period: _____
Pregnancies: _____ Births: _____ Miscarriages: _____

	No	Yes	
Prolonged or abnormal bleeding			Please describe:
Leakage of urine			Please describe:
Pelvic pain			Please describe:
Abnormal discharge			Please describe:
History of abnormal Pap Smear			Type of treatment:

Family History - Has any member of your family (including parents, grandparents and siblings) ever had the following:

ILLNESS	FAMILY MEMBER	ILLNESS	FAMILY MEMBER
Cancer (describe type)		Heart disease	
Hypertension (high blood pressure)		Diabetes	
Mental disease (anxiety, depression, etc.)		Strokes	
Drug or alcohol addiction		Arthritis	
Glaucoma		Bleeding diseases	
Other		Other	

Warren M. Levin, M.D., PLLC
Confidential Patient Health History

Please List and Supply the Dates of:

Surgeries: _____

Hospitalizations other than for surgery: _____

Have you ever had chiropractic care? (Circle one) No Yes When? _____ By Whom? _____
 For what? _____ Successful? No Yes

When was your last:

Pap smear? _____ Breast Exam? _____ Stool check for blood? _____
 Mammogram? _____ Cholesterol Check? _____ Prostate Exam? _____

Supplements and Medications (include ALL supplements, over-the-counter and prescription medications. Attach list if necessary.)

SUPPLEMENT/DRUG NAME	DOSE/FREQUENCY	SUPPLEMENT/DRUG NAME	DOSE/FREQUENCY

Prevention:

Do you wear seat belts? No Yes If no, why not? _____
 Do you wear bike helmets? No Yes N/A
 Do you exercise regularly? No Yes If yes, type, duration and number of times per week: _____

Do you smoke? No Yes If yes, how many packs per day? _____
 Do you drink alcoholic beverages? No Yes If yes, how many packs per day? _____
 Do you drink coffee? No Yes If yes, how many cups per day? _____
 Do you drink tea? No Yes If yes, how many cups per day? _____

If there is a gun in your home, do you keep it unloaded and out of children's reach? No Yes N/A
 Have you engaged in any activity that has put you at risk of getting AIDS? No Yes If yes, explain: _____

Do you wish to be tested for AIDS? No Yes
 Have you ever worked with chemicals, paints, asbestos or other hazardous materials? No Yes
 If yes, explain: _____

Do you feel afraid of your partner? No Yes N/A
 Method of birth control? _____

This Physician-Patient Arbitration Agreement ("Agreement"), effective as of the date last entered by the signatories at the end of this Agreement, is entered into by and between Warren M. Levin, M.D., and Warren M. Levin, M.D., PLLC (collectively, "Physician"), and the Patient or Patient's Representative whose signature appears at the end of the Agreement ("Patient"), and provides as follows:

1. **AGREEMENT TO ARBITRATE:** Physician and Patient agree that any claim or controversy as to medical malpractice, that is as to whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to binding arbitration as provided by Virginia law, and not by a lawsuit or resort to court process except as Virginia law provides for judicial review of arbitration proceedings. Both parties to this Agreement, by entering into it, are giving up their rights to have any such dispute decided in a court of law before a jury, and instead both are accepting the use of arbitration. This Agreement shall apply to all medical services rendered at any time for any condition.

2. **ALL CLAIMS MUST BE ARBITRATED:** It is the intention of the parties that this Agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the Physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "Patient" herein shall mean both the mother and the mother's expected child or children. All claims for monetary damages against the Physician, and the Physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for wrongful death, emotional distress or punitive damages. Filing of any action in any court by the Physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

3. **PROCEDURES AND APPLICABLE LAW:** Within fifteen days after a party to this Agreement has given written notice to the other of demand for arbitration, the parties shall each appoint an arbitrator and give notice of such appointment to the other. Within a reasonable time after such notices have been given, the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator. Expenses of the arbitration shall be shared equally by the parties to this Agreement.

The parties agree that provisions of Virginia law applicable to arbitration of medical malpractice claims shall apply to disputes within this Agreement, including, but not limited to, Chapter 21 (§ 8.01-577 et seq.) of Title 8.01 and § 8.01-581.12 of the Code of Virginia.

4. **GENERAL PROVISIONS:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (a) on the date notice thereof is received, the claim, if asserted in a civil action, would

be barred by the applicable Virginia statute of limitations, or (b) the Patient or claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by Virginia law relating to arbitration.

5. **REVOCATION:** The Patient or claimant or his guardian, conservator, committee or personal representative may withdraw from this Agreement, and decline to submit any matter in controversy, within a period of sixty days after the termination of health care. If the patient is under disability by reason of age and at the time of termination of health care without a guardian who could take such action for him, or if he is incapacitated and without a guardian or conservator who could take such action for him, or if such termination is by death or if death occurs within sixty days after termination, then withdrawal from this Agreement must be within a period of sixty days after the appointment and qualification of the guardian, conservator or committee or personal representative of the Patient or claimant.

For purposes of this Agreement, "termination of health care" shall mean the last day that the Physician provided medical services to the Patient.

6. **VALIDITY AND ENFORCEABILITY:** If any provision of this Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. This Agreement shall be construed and enforced in accordance with the laws of the Commonwealth of Virginia.

BY SIGNING THIS AGREEMENT, YOU ARE AGREEING TO HAVE ANY MEDICAL MALPRACTICE ISSUE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO HAVE ANY SUCH ISSUE(S) DECIDED BY A COURT OR JURY.

By the signature below, Patient acknowledges receipt of a copy of the Agreement.

By: _____ Date _____
Patient

OR

By: _____ Date _____
Patient's Representative (and Relationship)

By: _____ Date _____
Physician

#1571489v2

Patient Medicare Notice

This agreement is between Dr. Warren M. Levin, MD (the Physician), whose place of business is 407 Church Street, NE, Vienna, VA 22180 and (Patient) _____, (who resides at) _____, who is a Medicare Part-B beneficiary seeking services covered under Medicare Part-B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed the patient that the physician has opted out of the Medicare program effective 10/18/06 for a period of at least two years, and is not excluded from participating in Medicare Part-B under sections 1128, 1156, 1892, or any other section of the Social Security Act.

Physician agrees to provide the following medical services to Patient:

Complementary and Alternative Medical Care

The Patient agrees to make payments to Physician in exchange for the services. Patient also agrees, understands and expressly acknowledges the following: (*in initial*)

___ Patient agrees not to submit a claim (or request that Physician submit claim) to the Medicare program with respect to the services, even if covered by Medicare Part-B

___ Patient is not currently in an emergency or urgent care situation.

___ Patient acknowledges that neither Medicare’s fees limitations nor any other Medicare reimbursement regulations apply to charges for the services.

___ Patient acknowledges that Medicare-supplemental plans will not provide payment or reimbursement for the services because payment is not under the Medicare program and other supplemental insurance plans may likewise deny reimbursement.

___ Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

___ Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for services, and acknowledges that Physician will not submit a Medicare claim for the services and that no Medicare reimbursement will be provided.

___ Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.

___ Patient acknowledges that a copy of this contract has been made available to him.

___ Patient agrees to reimburse Physician for any cost and reasonable attorneys’ fees that result from a violation of this Agreement by Patient or his beneficiaries.

Executed on _____ by _____
(Date) (Patient)

Patient Signature _____