Tasmina Sheikh, M.D., P.A.

Diplomate of the American Board of Psychiatry and Neurology
4600 Military Trail, Suite 221 Jupiter, FL 33458
561-625-9695 or Fax: 561-625-9745

Patient Demographic Information, please fill out completely

Last Name: _____ First Name: _____ Date of Birth:_____ Sex: M F

Address: _____City_____ State_____ Zip_____

Preferred Phone: _____ or _____

Email Address: _____

Social Security Number: _____ Driver License Number: _____

Employer: _____ Occupation:_____

Work Phone:_____

Marital Status: ☐ Single ☐Married ☐Divorced ☐Widow

Spouse's Name: _____

Primary Care Physician: _____ Phone: _____

Therapist: _____ Phone:_____

Pharmacy Name/Location:_____ Phone:_____

In the event of an emergency, please contact:

Name:_____ Phone:_____ Relationship:_____

If the patient is a minor or has a guardian, please complete below:

Parent/Guardian Name: _____ Phone:_____

Relationship to patient: _____

Please provide the office with current copies of your insurance cards and ID. Keep us informed of any changes in address, phone number or insurance. Having up to date records ensures that we may properly bill your insurance.

By signing below, I am attesting that all information provided is true and current to the best of my knowledge.

Patient/Guardian (print): _____

Patient/Guardian (sign):_____

Date:_____

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OFFICE POLICIES

1. **HOURS:**
    a. Dr. Sheikh enforces the following office hours: Monday-Thursday 9 AM to 4:20 PM
    b. Should you need to make an appointment or speak with our office staff, we enforce the following phone hours: Monday-Thursday 9:00A-12:00P; 1:00P-5:00P and Friday 9:00A-1:00P
2. **MEDICATIONS:**
    a. Medications are to be called in on week days only, absolutely no weekend prescriptions. Please provide at least 3 days notice on all refill requests.
    b. Controlled substances: No early refills will be allowed and we will not replace lost or stolen prescriptions.
    c. Sample medications may be issued on a trial basis only. This is done as a courtesy, not an obligation.
    d. Abuse/Misuse of medications and/or "Dr. Shopping" are absolutely prohibited and warrant discharge. Any persons caught forging or altering a prescription will be reported to the proper authorities.
3. **APPOINTMENTS**:
    a. Please keep your scheduled appointment. Reminder calls are a courtesy only, it is the patient's responsibility to remember their appointment.
    b. Please contact the office if you will be running more than 15 minutes late, we may need to reschedule your appointment.
4. **DELAYS:** From time to time, Dr. Sheikh's schedule may be delayed due to unexpected circumstances. Please be understanding and compassionate so we may allow appropriate time for each patient.
5. **COPAYS AND DEDUCTIBLES:** Co-payments, deductibles, and/or co-insurance payments are due at the time of each visit. Any and all unpaid balances are due to each appointment. We accept Cash, Credit and Debit (VISA, MASTERCARD, DISCOVER). We do not accept checks as a form of payment
6. **FORMS/LETTERS:** Dr. Sheikh reserves the right to refuse to complete any such paperwork deemed unnecessary or unwarranted. Short-Term Disability, Social Security, Emotional Support Pets, and/or Jury Duty forms **will not be filled out prior to your first three visits.** You must keep ALL scheduled appointments if you are on disability or short term leave. **No long term disability paperwork will be done for any patient.**
7. **PATIENT DISCHARGE:** Dr. Sheikh reserves the right to discharge any patients under the following:
    a. Any patient behaving in a rude, inappropriate or disruptive manner
    b. Any patient that does not comply with appointment follow ups or doctor recommendations.

I have read and understand the policies of this office and agree to the terms herein.

_____ _____

Patient signature **Date**

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FEES

Here at Dr. Tasmina Sheikh's office, we understand how important your time is. We work hard to minimize our patient wait times and to keep our office running on schedule. Please provide at least 24 hour notice if you are unable to attend an appointment. Please be aware of the following policies and fees:

Please initial each line

1. Any co-pays, out of pocket expenses, or current balances must be paid at check-in, prior to your appointment. _____
2. If you arrive without any means to pay, we will cancel your appointment and ask you to reschedule (a $25 cancellation fee will be applied to your account). _____
3. A $50 office fee will be applied to your account if you cancel a scheduled appointment with less than 24 hours notice. _____
4. A $75 office fee will be applied to your account if you do not show up for an appointment and do not provide notice._____
5. A $25 office fee will be applied to your account if you show up more than 15 minutes late to a scheduled appointment, but can still be seen. _____
6. A $50 office fee will be applied to your account if you show up more than 15 minutes late to a scheduled appointment and have to reschedule your appointment. _____
7. Dr. Sheikh reserves the right to perform random drug testing in order to ensure safety and compliance of medications. A $25 office fee will be applied in the event an in-office drug test is required. _____
8. Dr Sheikh will provide enough medication refills to last until your next recommended follow up appointment. Should you miss a follow up appointment and require an interim prescription to be written, a $30 office fee will be applied. _____
9. $25-$50 administrative fee will be charged for any forms or letters that the doctor or office must complete. _____
10. Dr Sheikh allows a maximum of 3 same day cancellations/no shows before discharging a patient due to non-compliance. _____

By signing below, I understand and agree to the above mentioned terms.

_____ _____

Patient signature Date

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RELEASE/REQUEST OF INFORMATION

*Having properly created and preserved a medical record, **a physician must ensure the record remains confidential**. Section 456.057(5), Florida Statutes. Nevertheless, the physician must, upon request, furnish the patient or its legal representative with a copy of "all reports and records relating to [the patient's] examination or treatment…)other than AIDS, mental, and substance abuse records.)," although a psychiatrist or psychologist may substitute a report of the examination in lieu of the medical record. Section 456.057(4), Florida Statutes. Medical records of a psychiatric nature will not be given to patients under any circumstance, unless approved by Dr. Tasmina Sheikh, MD, PA.

PATIENT NAME:_____

I GRANT PERMISSION FOR THE RELEASE / REQUEST OF ALL MEDICAL RECORDS INCUDING LABS, NOTES, TESTS, ETC… (CHECK ALL THAT APPLY)

COPIES OF PATIENT MEDICAL RECORDS MAY BE FORWARDED TO:
(I.E. MEDICAL DOCTOR, THERAPIST, LAW OFFICE)

_____ _____

_____ _____

_____ _____

COPIES OF PATIENT MEDICAL RECORDS MAY BE REQUESTED FROM:
(I.E. MEDICAL DOCTOR, THERAPIST, PAST PSYCHIATRIC RECORDS)

_____ _____

_____ _____

_____ _____

INFORMATION REGARDING PATIENT CASE MAY BE DISCLOSED TO:
(I.E. EMERGENCY CONTACT)

_____ _____

_____ _____

_____ _____

I authorize the office of Tasmina Sheikh, MD, PA to confirm (my/the patient's) scheduled appointments in the following manner: Home, cell or work phone, answering machine, voicemail box, or email. _____*initial here*

I authorize the office of Tasmina Sheikh, MD, PA to inquire about or share (my/the patient's) medication information to the preferred pharmacy on file on (my/the patient's) behalf. _____*initial here*

HIPAA COMPLIANCE NOTICE: I acknowledge that I have been informed of the HIPAA compliant regulations and I am fully aware of my rights with regard to the protection of my medical records and other pertinent information pertaining to my medical care.

Patient/Legal Guardian Signature:_____ Date:_____
Printed Name:_____ Relationship to Patient:_____
Witness: _____

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PATIENT QUESTIONNAIRE

Patient Name:_____

Please check accordingly:

	YES	NO
1. DID/DO YOU HAVE ANY UNWANTED IDEAS, IMAGES OR IMPULSES THAT SEEM SILLY, NASTY OR HORRIBLE?	_____	_____
2. DO YOU WORRY EXCESSIVELY ABOUT DIRT, GERMS OR CHEMICALS?	_____	_____
3. ARE YOU CONSTANTLY WORRIED THAT SOMETHING BAD WILL HAPPEN BECAUSE YOU FORGOT SOMETHING IMPORTANT; SUCH AS LOCKING THE DOOR OR TURNING OFF APPLIANCES?	_____	_____
4. ARE YOU AFRAID YOU WILL ACT OR SPEAK AGGRESSIVELY WHEN YOU REALLY DON'T WANT TO?	_____	_____
5. ARE YOU ALWAYS AFRAID THAT YOU WILL LOSE SOMETHING OF IMPORTANCE?	_____	_____
6. ARE THERE THINGS YOU FEEL YOU WILL DO EXCESSIVELY OR THOUGHTS YOU MUST THINK REPEATEDLY IN ORDER TO FEEL COMFORTABLE?	_____	_____
7. DO YOU FIND YOURSELF THINKING OF THINGS EXCESSIVELY?	_____	_____
8. DO YOU HAVE TO CHECK THINGS OVER AND OVER AGAIN OR REPEAT THEM MANY TIMES TO BE SURE THAT THEY ARE DONE PROPERLY?	_____	_____
9. DO YOU AVOID SITUATIONS OR PEOPLE YOU WORRY ABOUT HURTING BY AGGRESSIVE WORDS OR ACTIONS?	_____	_____
10. DO YOU KEEP MANY USELESS THINGS BECAUSE YOU FEEL THAT YOU CAN'T SAFELY THROW THEM AWAY?	_____	_____

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MEDICAL HISTORY

Patient Name:_____

	YOU	FAMILY		YOU	FAMILY
ARTHRITIS	_____	_____	LOW BLOOD PRESSURE	_____	_____
ASTHMA	_____	_____	LIVER PROBLEMS	_____	_____
CANCER	_____	_____	RESPIRATORY PROBLEMS	_____	_____
COLITIS	_____	_____	SEIZURES	_____	_____
DIABETES	_____	_____	SINUS PROBLEMS	_____	_____
ENDOCRINE DISEASE	_____	_____	STROKE	_____	_____
FAMILY DISEASE	_____	_____	STD'S	_____	_____
GASTRITIS	_____	_____	THYROID	_____	_____
GLAUCOMA/EYE DISEASE	_____	_____	TUBERCULOSIS	_____	_____
GOUT	_____	_____	ULCERS	_____	_____
HEART ATTACK	_____	_____	URINARY PROBLEMS	_____	_____
HIGH BLOOD PRESSURE	_____	_____	OTHER	_____	_____
HEPATITIS	_____	_____	_____		

DO YOU SMOKE? YES_____NO_____ HOW MUCH PER DAY?_____ STARTING YEAR_____

HAVE YOU PREVIOUSLY SMOKED? YES_____ NO_____ APPROXIMATE DATES:_____

PREVIOUS SURGERIES:_____

_____

_____

PREVIOUS NON-SURGICAL HOSPITALIZATIONS:_____

_____

_____

DRUG ALLERGIES, PLEASE LIST REACTIONS:_____

_____

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PSYCHIATRIC SYMPTOMS

Patient Name:_____

Please circle all that you feel apply

HEADACHES
DIZZINESS
FAINTING SPELLS
STOMACH PROBLEMS
HEART PALPITATIONS
FATIGUE
SLEEP PROBLEMS
SHAKING
DEPRESSED
WANT TO HURT SELF
SEX PROBLEMS
DRUG PROBLEMS
UNABLE TO RELAX
BORED
UNLOVED
NOT CONFIDENT
SYMPATHETIC
GOOD PERSON
INTELLIGENT
CAN'T KEEP A JOB
GUILTY
PUSHY
HATEFUL
INFERIORITY FEELINGS
TIMID
CAN'T CONCENTRATE
LAZY
INVISIBLE
APPRECIATED

NAÏVE
DON'T TAKE VACATIONS
WORTHWHILE
MEMORY PROBLEMS
POOR HOME LIFE
ATTRACTIVE
CONSIDERATE
REGRETFUL
LONELY
DEFORMED
MISUNDERSTOOD
RESTLESS
INADEQUATE
WORTHLESS
LIFE IS EMPTY
STUPID
HORRIBLE THOUGHTS
INCOMPETENT
NERVOUS
EVIL
COWARDLY
OVER AMBITIOUS
CAN'T MAKE DECISIONS
CONFUSED
ALWAYS BLAMES OTHERS
PERFECTIONIST
INVINCIBLE
JEALOUS
OTHER_____

CAN'T MAKE FRIENDS
CONFIDENT
LIKE TEACHERS
HAD MANY FRIENDS
DROPPED OUT OF SCHOOL
HAD FEW FRIENDS
DID POORLY
DISLIKED SCHOOL
NEVER SENT TO PRINCIPAL
WAS A GOOD STUDENT
WAS EXPELLED

CHILDHOOD ISSUES

SLEEP WALKING
CHILDHOOD FEARS
HAPPY CHILDHOOD
FIGHTING
NAIL BITING
BED WETTING
STAMMERING
UNHAPPY CHILDHOOD
THUMB SUCKING
SHY
GOOD RELATIONSHIPS
NIGHT TERRORS
SOIL CLOTHES

Please state in your own words why you are seeking professional help today: _____
_____
_____
_____

How long have you had these problems? _____ Have you attempted to seek help before now?_____

With whom?_____

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MEDICATION LIST

Patient Name_____ Date of Birth_____

CURRENT MEDICATIONS: Please list all medications you are currently prescribed

MEDICATION	STRENGTH + DOSAGE	PRESCRIBING DOCTOR

PRIOR MEDICATIONS: Please list all **psychiatric** medications that you have previously been prescribed.

MEDICATION	DATES PRESCRIBED	RESULT OF MEDICATION (positive/negative effect)

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AUTHORIZATION FOR INSURANCE TO PAY

I hereby authorize and request my insurance company to directly pay Tasmina Sheikh, MD, PA the amount due for medical services rendered.

Patient Name_____

Date of Birth:_____ Social Security#: _____

Signature of Insured:_____ Date:_____

I further understand that should my claim not be paid by my insurance company within 90 days, I accept full responsibility for all unpaid balances. I understand that if my account has any unpaid charges that require they be sent to collections, I agree to pay any and all collection fee charges. I understand that if any authorization needs to be obtained in order for my visits to be covered, it is my responsibility to contact my insurance company prior to my visit.

RELEASE OF INFORMATION FOR INSURANCE

I hereby authorize Tasmina Sheikh, MD, PA to release any pertinent information about my treatment and diagnosis to my medical insurance for claims processing.

Patient Name:_____

Signature of Insured:_____ Date:_____

Witness Signature_____ Date:_____