NAZRUL ISLAM, MD, PA
REQUEST FOR NEW PATIENT APPOINTMENT:

NOTE: FILLING THIS FORM DOES NOT CONSTITUTE ACCEPTANCE TO OUR SERVICES

IF ACCEPTED WE WILL CALL YOU WHEN WE HAVE A NEW PATIENT AVAILABILITY

Your full name: _____

Best number to reach you: _____ Alternate number: _____

Date of Birth: _____ Age: _____ Gender: _____

You are referred by: _____

Mental Health Insurance Carrier Name: _____
*(**Note:** This can be **different** from your general insurance. If unsure please call your insurance company and get the information)*

Have you been terminated by your previous provider: ☐Y ☐N

Are there charges pending against you: ☐Y ☐N

Are you on probation for any reason: ☐Y ☐N

Are you required by law to see a Psychiatrist: ☐Y ☐N

Is this evaluation going to be used in any shape or form for:

(a) Custody ☐Y ☐N
(b) Disability, **FMLA**, Work Hours, School etc ☐Y ☐N
(c) Any other accommodation ☐Y ☐N

Are you expecting us to validate an ongoing disability or other paper work: ☐Y ☐N

Have you been sober from Alcohol, Street Drugs or Prescription drug abuse for at least 120 days: ☐Y ☐N

Are you on Prescribed Pain Medication, If so which one(s): _____

Have you required (last 10 years) psychiatric hospitalization: ☐Y ☐N

Have you required (last 10 years) urgent access to mental health: ☐Y ☐N

Have you ever attempted suicide: ☐Y ☐N

Do you (last 10 years) have a history of self-cutting: ☐Y ☐N

Do you (last 10 years) have a history of multiple threats of suicide: ☐Y ☐N

In case you are not accepted as a new patient, the information above will be shredded within 15 days.

I AFFIRM THAT INFORMATION PROVIDED ABOVE IS TRUTHFUL

Please Sign:_____ Please Date:_____

Please clearly write your name: _____