Psychiatry Specialists of Ann Arbor P.C.
Phyllis M. Boniface MD
2355 East Stadium Blvd
Suite 9
Ann Arbor, Michigan 48104
(734) 741 8300

Dear New Patient,

Welcome to Psychiatry Specialists of Ann Arbor, P.C. We are pleased to be able to serve you. Dr. Boniface has scheduled you for an initial appointment at which time you will be evaluated by a thorough 75-80 minute interview and given a comprehensive treatment plan.

Because Dr. Boniface is an independent physician she does not participate with insurance networks and our office does not bill patient's health insurance directly. However, you will be provided with forms and documentation of medical codes and payment for services so that you may submit these to your insurer for possible reimbursement to you. Dr. Boniface no longer participates in Medicare.

Payment is required from patients at the time of service unless other arrangements are made with the doctor. The following is Dr. Boniface's fee schedule: Initial Consultation @ $490, Full Session 40-45 minutes @ $350, and Half Session (25-30 minutes) @ $250.

Dr. Boniface's office is at 2355 East Stadium Blvd, Suite 9, Ann Arbor, Michigan, 48104. There is free parking in the lot behind the building.

We look forward to serving you, and thank you.

Psychiatry Specialists of Ann Arbor, P.C. Phyllis Boniface MD

Phyllis Boniface, MD

Psychiatry Specialists of Ann Arbor, P.C.

2355 East Stadium Blvd, Suite 9, Ann Arbor, Michigan, 48104

Patient Information

First Name	Middle Name	Last Name

Today's Date	Date of Birth (mm/dd/yyyy)	Appointment date if known (mm/dd/yyyy)

Street Address

City	State	Zip Code

Home Phone	Mobile Number	Work Number

Email Address	Marital Status	Emergency Contact (Name, relationship and phone)

PLEASE NOTE:

Payment is required from patients at the time of service unless other arrangements are made directly with Dr. Boniface.

Dr. Boniface is "nonparticipating" with insurers and does not file insurance claims for patients to their insurers. However, you will be provided with all forms and documentation of medical codes and payment for services so that you may submit these to your insurer for possible reimbursement to you.

Dr. Boniface no longer participates in Medicare.

Please provide Dr. Boniface with at least 24 hours notice when changing or cancelling appointments to avoid being charge for a missed appointment.

Insurance Information

Items below marked with an asterisk (*) required only if patient is not the insured party

Full Name of the Insured Party*	Insured Party's Date of Birth * (mm/dd/yyyy)

Insured Party's Employer *	Insured ID

Insurance Company Name	Insurance Company Phone Number

Employer

Insurance Company for Pharmacy

Please let us know how you were referred to our practice:

___By my primary care physician ___By another physician involved in my care

___By a friend ___By a family member

___Internet/Website

___Other, please give us details: _____.

Please provide the name of your referring physician, therapist, etc.
_____.

Please briefly explain the reason that you are seeking help at this time:

Current Symptoms

Please check all that apply:

Addiction	Sleep—Problems Staying Asleep	Paranoid Thoughts
Appetite Decreased	Sleep—Problems Falling Asleep	Self Harm (cutting, hitting, burning)
Concentration Impairment	Violence Towards Others	Shopping/Spending Excessively
Destruction of Property	Anger	Sleep—Sleep is Not Refreshing
Excessive Sweating	Appetite Increased	Suicide Attempt(s) in the past
Feelings of Guilt	Constipation	Weight Gain
Hallucinations	Diarrhea	Anxiety
Impulsivity	Fatigue/Tiredness	Compulsions
Irritability	Feelings of Hopelessness	Depressed Mood
Mood Swings	Impaired Family Relationships	Dizziness
Overuse/Misuse of Alcohol	Inability to Enjoy Activities	Fear
Pain—Gastrointestinal	Loneliness	Gambling Excessively
Pain—Lower Extremities	Nausea	Impaired Productivity at Work/School
Panic Attacks	Overuse/Misuse of Recreational Drugs	Indecisiveness
Restlessness	Pain--General	Memory Impairment
Shakiness/Tremulousness	Pain--Shoulder	Obsessive Compulsive Symptoms
Pain—Back	Pain—Headache	Pain—Upper Extremities
Racing Thoughts	Sexual Difficulties	Suicidal Thoughts
Sleep—Waking too Early	Tearfulness	Weight Loss

Other:

Have you ever been diagnosed and/or treated for the following? Please check all that apply:

Anxiety Disorder	Mood Disorder, Depression	Phobias
Attention Deficit Disorder	Mood Disorder, Bipolar (Manic Depressive Disorder)	Personality Disorder
Anoxia	Obsessive Compulsive Disorder	Schizophrenia
Bulerria	Panic Disorder	Seasonal Affective Disorder
Eating Disorder	Post-Traumatic Shen Disorder (PTSD)	Substance Abuse, Chemical Dependency

Past Psychiatric History

Please provide details regarding past psychiatric services including names of clinicians, locations, and dates of treatments, etc.

Sleep Habits

What time do you most commonly go to bed?

How long does it usually take you to fall asleep?

How many times do you awaken during the night?

If you awaken, how long does it take to fall back to sleep?

What time do you most commonly wake in the morning?

Does your sleep feel refreshing? Are you well rested when you wake?

How many days per week do you nap?

If you take naps, how long do they last?

How many hours of sleep do you get most days?

Please indicate if you or your bed partner have ever noticed the following about your sleep?

___Fall asleep during the day without intending to do so

___Snore

___Briefly stop breathing or gasp for breath at night

___Notice involuntary jerking, movement, kicking of legs

___Feel the need to continuously move your legs or arms to try to get comfortable

___Sleepwalk

___Talk in sleep

___Experience visions or vivid dreams on the verge of falling asleep or waking up

___Feel noticeably weak or unable to move upon wake

Past Medical History

Please check all that apply:

Allergies	Cancer—Endometrial	Chronic Fatigue Syndrome
Bleeding Disorders	Cancer—Lymphoma	Connective Tissue Disease
Cancer—Basil Cell	Cancer—Squamous Cell Carcinoma	Endocrine System Problems
Cancer—Colon	Chronic Diarrhea	Eye/Vision Problems
Cancer—Lung	Congestive Heart Failure	GERD (Reflux)
Cancer--Ovarian	Digestive System Problems	Hearing Loss Problems
Chronic Constipation	Endometriosis	Hemorrhoids
Chronic Nausea	Gall Bladder Problems	High Triglycerides

Diabetes	Head Injury	Inflammation/Inflammatory Problems
Menstrual Cycle Start Before 13	Heart Disease—Coronary Artery Disease	Joint Problems
Fibromyalgia	High Cholesterol	Lung Disease
Gout	Infections (recurrent)	Migraine Headache
Heart Attack/Myocardial Infarction	Irritable Bowel Syndrome	Neurological Problems
High Blood Pressure	Liver Disease	Pain (chronic)
Hypoglycemia	Menopause	Peripheral Vascular Disease
Insomnia	Muscle Problems	Reproductive Problems
Kidney Disease	Osteoarthritis	Rheumatoid Arthritis
Lupus	Periodic Limb Movement	Sleep Apnea
Mouth/Tongue Problems	Premenstrual Syndrome	Stomach problems
Obesity	Rheumatic Fever	Stroke
Passing Out	Skin problems	Thyroid Disease—Hypothyroid
Pneumonia	Sleep Apnea—CPCP	Tuberculosis
Restless Leg Syndrome	Asthma	Teeth Problems
Seizures/Epilepsy	Cancer—Liver	Thyroid Disease—Hyperthyroid
Sleep Apnea—CPAP	Cancer—Breast	Urinary Tract Infections
Anemia	Cancer—Leukemia	Throat Problems
Bone Problems	Cancer—Melanoma	Tics/Involuntary Movements
Cancer—Bone	Cancer—Thyroid	Vision Loss

Past Surgical History

Please list any past surgeries/operations:

Allergies/Medication Intolerances:

Please indicate if you have had any of the following tests completed in the past:

___Sleep Study

___Psychological Testing

___Neuropsychological Testing

___Brain MRI or CT Scan

___EEG

___Thyroid Level

___Testosterone Level

___Hormone Level

Medications

Please list all of the current medications, which you take including the name, dose, and directions:

Please list all past psychiatric medications and approximates dates taken:

Substance Use

Substance Use History

	Please describe current use	Please describe past use
Alcohol		
Tobacco		
Caffeine		
Recreational Drugs		

Have you ever been involved in any type of treatment for substance use in the past or currently?

___No If yes, where _____

___Yes If yes, when _____

Review of Systems

Please indicate if you have any problems/issues with the following:

___Allergies
___Bleeding
___Bone
___Digestive System
___Endocrine System
___Eyes
___Hearing
___Heart or Blood Vessels
___Infections
___Inflammation
___Joints
___Lungs or Sinuses
___Mouth
___Muscles
___Neurological System
___Night Mares or Waking Up
___Pain and Location
___Passing Out
___Reproductive System or Menstrual Cycles
___Seizures
___Skin
___Sleep Walking
___Snoring
___Stomach
___Talking
___Teeth
___Throat

Family Psychiatric History

Please provide any information you have regarding any family history of psychiatric issues (i.e. depression, anxiety, bipolar disorder, substance abuse, schizophrenia, dementia, OCD, attention deficit disorder, suicide, etc.)

Social History

Education

___High School

___Vocational Degree

___Associates Degree

___Bachelors Degree

___Masters Degree

___Doctoral Degree

___Post-Doctoral Studies

___Professional Certification

Religious Background

___Christian (Protestant)

___Catholic

___Baptist

___Jewish

___Muslim

___Mormon

___Jehovah's Witness

___Agnostic

___Atheist

___Other

Sexual Orientation

___Heterosexual

___Homosexual

___Bisexual

Legal History

___None

___Speeding/Parking Ticket

___DUI

___DWI

___Probation—Past

___Probation—Current

___Other

Employment Status

Please describe the type of work you do: _____.

___Full Time

___Part Time

___Self Employed

___Student

___Homemaker

___Retired

___Disabled

___Unemployed

Miscellaneous Information

Pharmacy Preferences:

___I use a mail order pharmacy for 3 month supplies of medications

___I use a local pharmacy for a monthly supply of medications

___I use a local pharmacy for 3 month supplies of medications

Pharmacy Name
Pharmacy Address
City, State, Zip
Pharmacy Phone Number

Thank you for taking the time to provide this information, which, along with the detailed clinical interview, will help the physician provide accurate psychiatric diagnosis and treatment.