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| **Person Completing This Form** |
| Who is completing this application? [ ]  I would be the patient [ ]  I am the potential patient’s parent/guardian who is a minor (younger than the age of 18) [ ]  I am the legal healthcare proxy of the potential patient who is not a minor (older than the age of 18) |
| **ONLY for Parents & Guardians of Minors** |
| 1st Parent First Name       | 1st Parent Last Name       | 1st Parent Birth Date       | 1st Parent Phone Number       |
| 2nd Parent First Name       | 2nd Parent Last Name       | 2nd Parent Birth Date       | 2nd Parent Phone Number       |
| The Parent/Guardian applying on behalf of the potential patient must include a copy of his/her photo ID with the application which may include a State or Federal Government Issued Photo ID (i.e. Driver’s License, Passport, etc.) [ ]  I have included a copy of my photo ID with this application. |
| **ONLY for Healthcare Proxies** |
| Proxy First Name       | Proxy Last Name       | Proxy Birth Date       | Proxy Phone Number       |
| The Parent/Guardian applying on behalf of the potential patient must include a copy of his/her photo ID with the application which may include a State or Federal Government Issued Photo ID (i.e. Driver’s License, Passport, etc.) and a copy of the legal documentation that indicates that you are the legal healthcare proxy which may include but is not limited to a court order or executed NYS DOH 1430 form. [ ]  I have included a copy of my photo ID with this application. [ ]  I have included a copy of the Healthcare Proxy documentation as required. |

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| **General Information** |
| First Name       | Middle I.       | Last Name       | Date of Birth       |
| Sex [ ] Female [ ]  Male  | Marital Status [ ]  Legally Separated [ ]  Married [ ]  Other [ ]  Partnered [ ]  Single [ ]  Widowed |
| We need a copy of the your (the potential patient’s) photo ID with the application which may include a State or Federal Government Issued Photo ID (i.e. Driver’s License, Passport, etc.) [ ]  I have included a copy of my photo ID with this application. |
| **Residential Address** |
| Address       | Apt #       | City       | State       | Zip       |
| **Mailing Address (If Different)** |
| Address       | Apt #       | City       | State       | Zip       |
| **Contact Information** |
| Mobile Phone       | Home Phone       | Work Phone       | Email Address       |
| **Emergency Contact Information** |
| First Name       | Last Name       | Relation      | Phone Number       |
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| **Primary Health Insurance Policy** |
| Health Insurance Company       | Member ID       | Group Number       |
| We need a copy of the front and back of your insurance card to be included in the application to verify your health insurance benefits, eligibility, and for prescription drug coverage at your pharmacy. Include a copy in your application. [ ]  I have included a copy of the front and back of my health insurance card. |
| **Secondary Health Insurance Policy** |
| Health Insurance Company       | Member ID       | Group Number       |
| We need a copy of the front and back of your insurance card to be included in the application to verify your health insurance benefits, eligibility, and for prescription drug coverage at your pharmacy. Include a copy in your application. [ ]  I have included a copy of the front and back of my health insurance card. |
| **Tertiary Health Insurance Policy** |
| Health Insurance Company       | Member ID       | Group Number       |
| We need a copy of the front and back of your insurance card to be included in the application to verify your health insurance benefits, eligibility, and for prescription drug coverage at your pharmacy. Include a copy in your application. [ ]  I have included a copy of the front and back of my health insurance card. |

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| **Referral Source** |
| How did you hear about us?       |
| **Do you have a Primary Care Provider (PCP)?** |
| Name       | Practice Name       | Phone       |
| Address       | Suite       | City       | State       | Zip Code       |
| **Do you have a Psychiatrist or Psychiatric Nurse Practitioner?** |
| Name       | Practice Name       | Phone       |
| Address       | Suite       | City       | State       | Zip Code       |
| **Do you have a Psychotherapist? This may include a Psychologist (PHD or PSYD), Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor (LMHC) or Licensed Marriage and Family Therapist (LMFT).** |
| Name       | Practice Name       | Phone       |
| Address       | Suite       | City       | State       | Zip       |
| **Pharmacy** |
| Name       | City       | State       | Phone       |
| **Blood Laboratory Tests** |
| Have you had any blood laboratory tests performed in the past three years?        |
| Ordering Provider       | Laboratory Name       |
| **COVID-19 Vaccination** |
| Have you received an FDA Emergency Use Authorized or Approved vaccination for COVID-19?  [ ]  Yes [ ]  No |
| In what state were you vaccinated?       | Which vaccination did you receive? [ ]  Janssen [ ]  Moderna (2 doses) [ ] Pfizer (2 doses) |

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| **Desired Treatment & Services** |
| What brings you into our practice? |
|  [ ]  Abuse [ ]  Adolescent Issues [ ]  Alcohol Use Disorder [ ]  Anger [ ]  Anxiety [ ]  Attention Deficit/Hyperactivity Disorder [ ]  Autism Spectrum Disorders [ ]  Bipolar Disorders [ ]  Chronic Illness [ ]  Compulsive Gambling [ ]  Depression [ ]  Dementia [ ]  Disabilities [ ]  Eating Disorders: Anorexia [ ]  Eating Disorders: Bulimia [ ]  Eating Disorders: Binge Eating [ ]  Gender Dysphoria [ ]  Gender Issues |  [ ]  Infertility [ ]  Learning Disabilities [ ]  LGBT Issues [ ]  Marriage/Relationship Issues [ ]  Obesity [ ]  Obsessive/Compulsive Disorder [ ]  Pain Management [ ]  Personality Disorder [ ]  Phobias [ ]  Post-Traumatic Stress Disorder (PTSD) [ ]  Schizophrenia [ ]  Sexual Dysfunction [ ]  Sleep Disorders [ ]  Substance Use Disorder [ ]  Trauma [ ]  Traumatic Brain Injury (TBI) [ ]  Work/Auto Accident Related Injury |
| What services are you seeking at our practice? [ ]  Psychiatric Evaluation [ ]  Evaluation for Disability from Work [ ]  Evaluation for Disability in School [ ]  Psychiatric Medication Management |  [ ]  Individual Psychotherapy & Counseling [ ]  Family Psychotherapy & Counseling [ ]  Marriage Counseling |
| Are you open to being treated by telehealth? [ ]  Yes [ ]  No |
| **Current Medications** |
| Are you currently being prescribed by any of the following Benzodiazepine medications? |
|  [ ]  alprazolam (Xanax) | Dose:       | Day Supply:       |
|  [ ]  clonazepam (Klonopin) | Dose:       | Day Supply:       |
|  [ ]  chlordiazepoxide (Librium) | Dose:       | Day Supply:       |
|  [ ]  diazepam (Valium) | Dose:       | Day Supply:       |
|  [ ]  lorazepam (Ativan) | Dose:       | Day Supply:       |
| Are you currently being prescribed any of the following opioid medications? |
|  [ ]  fentanyl | Dose:       | Day Supply:       |
|  [ ]  hydrocodone (Vicodin) | Dose:       | Day Supply:       |
|  [ ]  morphine (Kadin, Avinza) | Dose:       | Day Supply:       |
|  [ ]  oxycodone (Percocet) | Dose:       | Day Supply:       |
|  [ ]  oxymorphone (Opana) | Dose:       | Day Supply:       |
|  [ ]  buprenorphine naloxone (Suboxone) | Dose:       | Day Supply:       |

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| **Availability for Treatment** |
| Select all the times that you are available for treatment throughout the week |
| Tuesday [ ]  11AM – 12PM [ ]  12PM – 1PM [ ]  1PM – 2PM [ ]  3PM – 4PM [ ]  4PM – 5PM [ ]  5PM – 6PM [ ]  6PM – 7PM [ ]  7PM – 8PM | Wednesday [ ]  9AM – 10AM [ ]  10AM – 11AM [ ]  11AM – 12PM [ ]  12PM – 1PM [ ]  2PM – 3PM [ ]  3PM – 4PM [ ]  4PM – 5PM [ ]  5PM – 6PM | Thursday [ ]  9AM – 10AM [ ]  10AM – 11AM [ ]  11AM – 12PM [ ]  12PM – 1PM [ ]  2PM – 3PM [ ]  3PM – 4PM [ ]  4PM – 5PM [ ]  5PM – 6PM | Friday [ ]  9AM – 10AM [ ]  10AM – 11AM [ ]  11AM – 12PM [ ]  12PM – 1PM [ ]  2PM – 3PM [ ]  3PM – 4PM [ ]  4PM – 5PM [ ]  5PM – 6PM |
| **Residency** |
| Are you a permanent resident of New York State? [ ]  Yes [ ]  No |
| Are you a full time or part-time resident of the East End Of Long Island? [ ]  Full-Time Resident [ ]  Part-Time Resident |
| **Additional Information** |
| Is there anything else you would like to share with us?       |