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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? | | | |