EAST END MENTAL HEALTH
Integrated Behavioral Health & Wellness

NEW PATIENT APPLICATION

Last Updated 09/22/2021

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

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.

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)			

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:

Availability for Treatment

Select all the times that you are available for treatment throughout the week

Tuesday	Wednesday	Thursday	Friday
	☐ 9AM – 10AM	☐ 9AM – 10AM	☐ 9AM – 10AM
	☐ 10AM – 11AM	☐ 10AM – 11AM	☐ 10AM – 11AM
☐ 11AM – 12PM	☐ 11AM – 12PM	☐ 11AM – 12PM	☐ 11AM – 12PM
☐ 12PM – 1PM	☐ 12PM – 1PM	☐ 12PM – 1PM	☐ 12PM – 1PM
☐ 1PM – 2PM			
	☐ 2PM – 3PM	☐ 2PM – 3PM	☐ 2PM – 3PM
☐ 3PM – 4PM	☐ 3PM – 4PM	☐ 3PM – 4PM	☐ 3PM – 4PM
☐ 4PM – 5PM	☐ 4PM – 5PM	☐ 4PM – 5PM	☐ 4PM – 5PM
☐ 5PM – 6PM	☐ 5PM – 6PM	☐ 5PM – 6PM	☐ 5PM – 6PM
☐ 6PM – 7PM			
☐ 7PM – 8PM			

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?