BRIDGEWAY
HEALTH SERVICES

New Patient Information

Patient Last Name: _____ **First Name:** _____ **MI:** _____

Date of Birth: _____/_____/_____ Sex: (circle one) Male or Female SS#: _____

Cell Phone: _____ Home Phone: _____

Street Address: _____ City: _____ State: ____ Zip:_____

Email: _____

Primary Language: _____ Race/Ethnicity: _____

Referring Physician: _____

Primary Care Provider: _____

Primary Insurance Information:

Insurance Company Name: _____

Name of Insured: _____

Street Address: _____City: _____ State: _____ Zip: _____

ID #: _____ Group #: _____

SS# of Insured: _____

Secondary Insurance Information:

Insurance Company Name: _____

Name of Insured: _____

Street Address: _____City: _____ State: _____ Zip: _____

ID #: _____ Group #: _____

SS# of Insured: _____

Emergency Contact Information:

Contact Name: _____ Relationship to Patient: _____

Cell Phone: _____ Home Phone: _____

Consent of File: Yes ☐ No ☐

Bridgeway Health Services provides quality recovery-oriented behavioral and mental health services and support to individuals in the community without regard to race, color, national origin, age, religion, philosophy, disability, sexual orientation, gender identification or gender expression. We strive to consistently provide an atmosphere of diversity, equity and inclusion within our organization and among the people we serve.

Health History

Height: _____ ***Weight:*** _____

Caffeine Use: YES / NO # _____ Cups per day of Coffee, Tea, or Soda?

Alcohol Use: YES / NO # _____ Drinks per Day, Week, or Month?

Tobacco Use: YES / NO # _____ Packs per Day?

Smokeless Tobacco Use? YES / NO

Are you currently taking any medications? YES / NO (Prescribed or Over the Counter)
If yes, Name of medication, dosage, how often? _____
_____

Do you have any current or ongoing medical problems? YES / NO
If yes, what is the problem and duration? _____
_____

Previous Medical Hospitalizations and/or Surgeries?: _____
_____

Prior Therapy/Counseling?: YES / NO If yes, name of therapist, when and duration?:
_____
_____

Prior Psychiatric Hospitalization? YES / NO If yes, where, where, duration, diagnosis, and medication given? _____
_____

Family History of Mental Illness? YES / NO If yes, who? Mother, Father, Sister, brother, Aunt, Uncle, Grandparents? _____
_____

Current or Prior Substance Use? Alcohol / Drugs / Both:
_____

Family History of Substance/Alcohol Abuse?: YES / NO If yes, who?
_____
_____

Allergies to Medications?:
_____

Please explain why you are here today:_____
_____
_____

Parent/Guardian Signature: _____ **Date:** _____