Pediatric New Patient Information

Patient Last Name: ______________________ **First Name:** ____________________ **MI:** ________ **Sex: M/F**

Date of Birth: ___/____/______ SS#: _____________ Cell Phone: _______________ Home Phone: ____________

Street Address: ____________________________________ City: ________________ State: ____ Zip:_______

Email: ________________________ Primary Language: ___________________ Race/Ethnicity: ____________

Referring Physician: ____________________________________

Pediatrician: ____

Parent/Guardian 1 Information: Relationship to patient (circle one) Mother Father Other:____________

Last Name: ____________________ First Name: __________________ MI: _________ Sex: M/F

Street Address: ____________________________________ City: ________________ State: ____ Zip:_______

Email: _______________________ Date of Birth: _____________ SS# ______________________

Cell Phone: ___________________ Home Phone: _________________ Work Phone: ___________________

Parent/Guardian 2 Information: Relationship to patient (circle one) Mother Father Other:____________

Last Name: ____________________ First Name: __________________ MI: _________ Sex: M/F

Street Address: ____________________________________ City: ________________ State: ____ Zip:_______

Email: _______________________ Date of Birth: _____________ SS# ______________________

Cell Phone: ___________________ Home Phone: _________________ Work Phone: ___________________

Parents are: Married/ Single/ Divorced (please circle)

*Note: *If any special parental or custodial relationship (such as custody with one parent only, legal custody/guardians with no parent, etc.) is in place, please explain in the space below with your signature, printed name, and a phone number at which you can be contacted.*

____

____

Signature: _________________________________ Print Name: _________________________Phone: _______________

Emergency Contact Information:

Contact Name: _____________________ Relationship to Patient: _________________

Cell Phone: ____________________ Home Phone: ___________________ Consent of File: Yes ☐ No ☐

Primary Insurance Information:

Insurance Company Name: ____________________________ Name of Insured: Parent 1 ☐ Parent 2 ☐

Street Address: ____________________________________ City: ___________ State: ______ Zip: _________

ID #: _________________________ Group #: ___________________ SS# of Insured: ________________

Secondary Insurance Information:

Insurance Company Name: ____________________________ Name of Insured: Parent 1 ☐ Parent 2 ☐

Street Address: ____________________________________ City: __________ State: ______ Zip: ________

ID #: _______________________ Group #: __________________ SS# of Insured: ________________

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:** _______________