



PATIENT INFORMATION

Date of Visit: _____

Brennan T. Dodson, MD

First: _____ Middle: _____ Last: _____

Date of Birth: ___/___/___ Age: ___ Social Security #: ___-___-___ Gender: M F Marital Status: S M D W

Mailing Address: _____ City: _____ State: _____ Zip: _____

Best Phone #: _____ Cell Phone #: _____ Work Phone #: _____

OK to leave a detailed message, including results? Y N

Email Address: _____

Primary Care Doctor: _____ Referring Doctor: _____

Y N I authorize Bridger ENT to send medical records to my listed primary care physician to improve the continuity of my care

Pharmacy: (Please include City) _____

How did you hear about our office? _____

Preferred language: English Spanish Other _____

Preferred Contact: Email Text Phone Other _____

Race: Caucasian Asian African-American Other _____

Ethnicity: Hispanic Non-Hispanic Other _____

PRIMARY INSURANCE

Insurance Company Name _____

Policy Holder _____ Policy Holder's Date of Birth _____

Policy Number _____ Group/Plan Number _____

Policy Holder's Phone _____ Alternate Phone _____

Insured's Employer _____ Relationship to patient _____

SECONDARY INSURANCE

Insurance Company Name _____

Policy Holder _____ Policy Holder's Date of Birth _____

Policy Number _____ Group/Plan Number _____

Policy Holder's Phone _____ Alternate Phone _____

Insured's Employer _____ Relationship to patient _____

MINORS (under 18 years of age) Minors must be accompanied by a legal guardian.

Father's Name _____ Employer _____ DOB _____

Address _____ Best Phone _____ SS# _____

Mother's Name _____ Employer _____ DOB _____

Address _____ Best Phone _____ SS# _____

May we discuss the patient's care with both parents? Y N

Emergency Contact: _____ Relationship: _____ Best Phone: _____

I consent to the release of medical information to my insurance company and to such other organizations as may be permitted under the Health Insurance Portability and Accountability Act (HIPAA). I acknowledge that I have received the Notice of Privacy Policy. I authorize and request that any insurance benefits be paid directly to Bridger Ear, Nose & Throat, PLLC. I understand the financial policies of this practice and agree that I am responsible for the balance on my account. If it becomes necessary to send my account to collection for non-payment, I will be responsible for all collection and legal fees incurred.

Signature: _____ Printed Name: _____ Date: _____

Relationship to Patient: _____



CHIEF COMPLAINT: What is the reason for your visit? _____

CURRENT MEDICATIONS, HERBALS, OR SUPPLEMENTS: (*Doses & Schedule*)

Drug	Dose & Schedule	Drug	Dose & Schedule

MEDICAL HISTORY: (i.e. Diabetes, High Blood Pressure, Cancer)

MEDICATION ALLERGIES:

Drug	Reaction	Drug	Reaction

OTHER ALLERGIES: (*Food, Etc.*)

Substance	Reaction	Substance	Reaction

SURGERY HISTORY: (*Year and Surgery*)

FAMILY MEDICAL HISTORY: (Please check all that apply)

	Allergies	Asthma	Autoimmune Disorder	Blood Disorder	Cancer (type)	Diabetes (type I or II)	Heart Disease	Stroke	Thyroid Disease	Other
Father										
Mother										
Sibling(s)										
Children										
Maternal Relatives										
Paternal Relatives										



Brennan T. Dodson, MD

SOCIAL HISTORY:

Cigarettes			<i>(circle one)</i>	
			<input type="radio"/> current smoker <input type="radio"/> former smoke <input type="radio"/> never a smoker	<input type="radio"/> every day smoker <input type="radio"/> some days smoker <input type="radio"/> smoker, current status unknown <input type="radio"/> unknown if ever smoked
Y	N	Tobacco	Type	Quantity/Past Use
Y	N	Caffeine	Type	Quantity
Y	N	Alcohol	Type	Quantity
Y	N	Illegal Drugs	Type	Quantity

STUDENTS/CHILDREN:

Y	N	Poor grades
Y	N	Trouble concentrating in school
Y	N	Hyperactivity
Y	N	Violent behavior
Y	N	Daycare

REVIEW OF SYSTEMS: (Please circle any symptom that applies to you)

General	Fever	Chills	Night Sweats	Loss of Appetite	Fatigue	Weight Loss/Gain
Eyes	Blurred Vision	Eye Pain	Tearing			
Ears	Hearing Loss	Ear Discharge	Ear Pain	Ringling in the Ears		
Nose	Nose Bleeds	Congestion	Sinus Pain	Seasonal Allergies	Snoring	
Throat	Hoarseness	Sore Throat	Voice Changes	Difficulty Swallowing		
Cardiovascular	Heart Attack	Chest Pain	Palpitations	Leg Swelling	Heart Murmur	
Respiratory	Sleep Apnea	Wheezing	Chronic Cough	Tuberculosis		
Gastrointestinal	Heartburn	Constipation	Frequent Diarrhea	Nausea/Vomiting	Blood in Stool	
Genitourinary	Kidney Stones	Painful Urination	Frequent Urination	Blood in Urine		
Musculoskeletal	Joint Swelling	Back Pain	Weakness			
Skin	Color Change	Cellulitis	Psoriasis	Rash		
Neurologic	Dizziness	Headaches	Poor Balance	Numbness/Tingling		
Hematologic	Enlarged Glands	Anemia	Bleeding Disorders			
Psychological	Depression	Anxiety	Trouble Sleeping	Memory Loss		