PRINCETON SPORTS & FAMILY MEDICINE

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New Patient Forms

Welcome and Thank You for Choosing Princeton Sports and Family Medicine!

Before your appointment, we ask that you **fill and sign the following forms** attached in this packet, along with sending us the other mentioned items:

- ☐ Patient Demographics
- ☐ HIPAA and Patient Authorization
- ☐ Past Medical History
- ☐ Copy of the front and back of your insurance card
- ☐ Copy of your driver's license or other valid photo ID (in color)

Other important things to do before coming to your appointment:

☐ Review our Patient Information/ Policy webpage

☐ Go to your patient portal

- You will have to agree to the patient consent form. This will automatically pop up when you enter your portal for the first time.
- On the dashboard, you will see any upcoming appointments, current medications, lab results, billing statements, and medical records.
- On the left side of the screen will be options.
    - To update your demographics, send portal messages to your provider, request medication refills and appointments, and review your medical records

☐ Save our phone number (609-896-9190) in the event that we need to reach you

Please send these completed forms to psfmed@gmail.com and include the patient's name, appointment time, and appointment date in the subject line.

PRINCETON SPORTS & FAMILY MEDICINE

2024 PATIENT DEMOGRAPHICS

Name _____ **MI** _____ ☐ Female ☐ Male

Mailing Address _____ **Apt** _____

City _____ **State** _____ **Zip** _____

Home Phone (_____) _____ - _____ **Cell Phone (_____)** _____ - _____

DOB ____/_____/_____ **SS#** _____-____-_____ **E-Mail** _____

Primary Care Physician _____ **PCP Phone # (___)** ____ - _____

Employer _____ ☐ Full ☐ Part ☐ Self ☐ Retired ☐ Unemployed ☐ Active Military

Student ☐ Full ☐ Part ☐ N/A **School** _____

Race ☐ African American ☐ American Indian ☐ Asian ☐ White ☐ Decline to Specify

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Language ☐ English ☐ Other _____

Emergency Contact _____ **Relation** _____ **Phone # (____)** _____-_____

INSURANCE INFORMATION

Primary Insurance _____ **ID Number** _____

Subscriber Name _____ **Subscriber DOB** ___/___/_____ **Relation** _____

Insurance Address _____ **City** _____ **State** _____ **ZIP** _____

Secondary Insurance _____ **ID Number** _____

Subscriber Name _____ **Subscriber DOB** ___/___/_____ **Relation** _____

Insurance Address _____ **City** _____ **State** _____ **ZIP** _____

_____ _____/_____/_____

PATIENT/PARENT/GUARDIAN SIGNATURE **DATE**

2024 HIPAA PATIENT PRIVACY FORM

THIS IS TO NOTIFY **PRINCETON SPORTS & FAMILY MEDICINE, PC** THAT I AM RESTRICTING THE RELEASE OF MY PROTECTED HEALTH INFORMATION. **NO** INFORMATION MAY BE RELEASED WITHOUT MY EXPRESS WRITTEN CONSENT AS INDICATED BELOW.

I HEREBY GIVE PERMISSION TO **PRINCETON SPORTS & FAMILY MEDICINE, PC** TO DISCUSS ANY MEDICAL MATTERS WITH THE FOLLOWING PERSON(S):

NAME **RELATIONSHIP**

_____

_____

_____

I authorize Princeton Sports & Family Medicine, PC to contact me in the following manner:

☐ Home Phone (____) _____
☐ Work Phone (____) _____
☐ Cell Phone (____) _____

☐ OK to leave a detailed voicemail
☐ OK to mail my home address
☐ Leave VM with callback number only

I would like to receive my appointment reminders in the following manner:

☐ VOICE ☐ TEXT ☐ EMAIL

BY SIGNING THIS FORM, I ACKNOWLEDGE AND UNDERSTAND THAT I CAN REVOKE THIS PERMISSION AT ANY TIME BY SUBMITTING A SIGNED STATEMENT, AND THAT PERMISSION WILL REMAIN IN EFFECT UNLESS WE RECEIVE A REVOCATION IN WRITING.

PATIENT NAME: _____ DOB: ___/____/____

PATIENT/GUARDIAN SIGNATURE: _____

DATE: ___/____/____

PLEASE *FLIP OVER* TO REVIEW OFFICE POLICIES!

PATIENT AUTHORIZATION

- I grant consent to all healthcare providers of **Princeton Sports and Family Medicine, PC.** to evaluate and treat.
- I consent to release to my insurance company any information required, including the diagnosis and records in the course of my exam and treatment.
- I understand that outside Healthcare and Educational Institutes may be participating in my treatment and care.
- I understand that all forms, letters, or paperwork filled out by a provider will be charged **$10.00 per form**. Where multiple forms are necessary the charge will be **$25.00** for all paperwork related to that incident. Please allow **7-10 business days** for all forms. Payment is due when forms are submitted.
- **CANCELLATION | NO SHOW POLICY:** We understand that there are times when you must miss your scheduled appointment due to emergencies or obligations for work or family. However, when you do not call to cancel your appointment, you may be preventing another patient from getting much needed treatment.
    - We require **at least 24 hours advance notice** to cancel or reschedule your appointment. **If your appointment is NOT CANCELLED at least 24 hours in advance, you will be charged a fee of $50.00.** This fee will NOT be covered by your insurance company.
- **INCOMING REFERRAL POLICY:** If your insurance requires a referral to see one of our specialist physicians, and we **DO NOT** have the referral, you will **NOT** be seen.
- **OUTGOING REFERRAL POLICY:** If your insurance requires a referral for specialist, labs, or images, we require a **72-hour notice** to submit your referral.
- **UNPAID BALANCES POLICY:** Any unpaid balances may be sent to payment agencies for collection.
- **RETURNED CHECK POLICY:** If your check is returned by your financial institution, you will be responsible for a **$40** return check fee.

PATIENT NAME: _____ DOB: ____/_____/_____

PATIENT/GUARDIAN SIGNATURE: _____

DATE: ____/_____/_____

PAST MEDICAL HISTORY

Name: _____ **DOB** _____/_____/_____

Height: _____ **Weight:** _____ **Gender:** ☐ **Male** ☐ **Female** ☐ **Other:** _____

Pharmacy: _____ **Occupation:** _____

Allergies and Reactions:

_____
_____
_____
_____

Current Medications:

_____
_____
_____
_____

Past Medical History/Chronic Medical Issues:

_____
_____
_____
_____

Past Surgeries (with dates):

_____
_____
_____
_____

Family Medical History:

_____
_____
_____
_____

Specialists/Other Doctors:

_____
_____
_____
_____

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnership

Children: # of sons: _____ # of daughters: _____

Do you drink alcohol? ☐ Yes ☐ No How often? _____ # of drinks per week: _____

Do you smoke? ☐ Yes ☐ No ☐ In the past # per day: ____ # years: ____ type: _____

Have you used drugs other than those for medical reason in the past 12 months? ☐ Yes ☐ No

Vaccine History (list dates):

_____ TDaP _____ Flu _____ COVID19

_____ Pneumonia _____ Shingles _____ HPV

_____ Hepatitis B _____ Meningitis

PREVENTATIVE HEALTH QUESTIONNAIRE

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Little interested or pleasure in doing things

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed, or hopeless

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Have you had a flu shot this year? ☐Yes ☐ No

If yes, where? _____ when? _____

Have you ever had a mammogram? ☐ Yes ☐ No

If yes, where? _____ when? _____

Have you ever had a colonoscopy? ☐ Yes ☐ No

If yes, where? _____ when? _____

Did you know it is recommended you exercise at least 150 minutes per week?
How often do you exercise?

_____ times per weeks

Name: _____ **DOB** _____/_____/_____