3131 Princeton Pike Bld. 4A, Suite 100
Lawrenceville, NJ 08648
P: (609) 896-9190   F: (609) 896-3555

50+ 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.

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 (____) ________________ __ OK to leave a detailed voicemail
__ Work Phone (____) ________________ __ OK to mail my home address
__ Cell Phone (____) ________________ __ 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 *<u>FLIP OVER</u>* 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

PATIENT PREVENTATIVE CARE QUESTIONNAIRE

Patient Health Questionnaire (PHQ-9)
Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use “x” to indicate you answer)

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling down, depressed, or hopeless	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired or having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself or that you are a failure, or have Let yourself or family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8) Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9) Thoughts that you would be better off dead or hurting yourself in some way	☐	☐	☐	☐

Have you had a flu shot this year? ☐ Yes ☐ No
If yes, where? ____________________ when? ____________________

Have you had a pneumonia vaccine? ☐ Yes ☐ No
If yes, where? ____________________ when? ____________________

Have you ever had a mammogram? ☐ Yes ☐ No
If yes, where? ____________________ when? __________ ☐ Normal ☐Abnormal

Have you had a bone density test (DEXA)? ☐Yes ☐ No
If yes, where? ____________________ when? __________ ☐ Normal ☐Abnormal

Have you ever had a colonoscopy? ☐ Yes ☐ No

If yes, where? ____________________ when? __________ ☐ Normal ☐Abnormal

If you are diabetic, have you had a vision test in the last year? ☐ Yes ☐ No

If yes, where? ____________________ when? ____________________

Have you had any falls this year? ☐ Yes ☐ No

If yes, how many? ____________________ when? ____________________
Did any result in injury? ____

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

__________ times per weeks

Name: ______________________________ DOB _____/______/______