PRINCETON MEDICAL INSTITUTE

NEW PATIENT REGISTRATION

PLEASE PRINT INFORMATION

Name	FIRST MIDDLE LAST			**Date:**	
Date of Birth:				**Age:**	
Gender:	☐ M ☐ F	**Race:**		☐ Hispanic ☐ Non-Hispanic	
Currently Employed:	☐ NO ☐ YES	**Occupation:** (Current OR Previous)			
Marital Status:	☐ Married	☐ Divorced	☐ Widowed	☐ Single	

CONTACT INFORMATION:

Primary Phone:				**Type:** ☐Home ☐Cell ☐Work ☐Other	
Secondary Phone:				**Type:** ☐Home ☐Cell ☐Work ☐Other	
Email Address:				**SS :**	___-___-____
Street Address:				**Apt #:**	
City:		**State:**		**Zip:**	

EMERGENCY CONTACT INFORMATION:

Name:		**Relationship:**	
Phone:		**2nd Phone:**	

ALLERGIES (medication, food, other)

Allergy:	**Reaction:**

Indication of Study:	
Referral Source:	

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MEDICAL HISTORY

Name:	Date of Birth:

Please list below any surgeries, hospitalizations, seizure history, cancer or other significant medical events / diagnoses that you have had. We need **AT LEAST** your best guess for the year of each date.

Condition / Event	Date Diagnosed	Date Resolved	Continuing?	Treated with Medication?

Please list below any medications you currently take, or have taken in the past 3 months.
We need AT LEAST your best guess for the year of each date.

Medication	Indication	Dose	Frequency	Route	Start Date	Stop Date	Continue? Y or N

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PHARMACY / PHYSICIAN HISTORY

Name:	Date of Birth:

Please list below any pharmacies you may have used in the past 3 years:

Name	Address	City / Town	Phone	Fax

Please list below any doctors you have seen in the past 5 years:

Name	Specialty	Address / City	Phone	Fax

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SUBSTANCE USE

Name:	Date of Birth:

Tobacco Use:

Have you ever smoked / used tobacco products?	€Yes €No
If **yes**, do you currently smoke / use tobacco products? Specific product: Average daily consumption:	€Yes €No
If **no**, when did you stop? (please give at least the year)	

Caffeine / Stimulant Consumption:

Do you currently consume caffeine or xanthenes or other stimulants? Specific product: Average daily consumption:	€Yes €No

Alcohol Consumption:

Do you currently consume alcohol?		€Yes €No
If Yes:	What is your average weekly consumption of beers (1 beer = 12oz)?	
	What is your average weekly consumption of wines (1 wine = 5oz)?	
	What is your average weekly consumption of spirits (1 spirit = 1.5oz)?	

Recreational Drug Use:

Have you ever used recreational drugs?		€Yes €No
If Yes:	Please check all that apply and date last used:	
	€Amphetamine _____	€Phencyclidine _____
	€Barbiturate _____	€Inhalant _____
	€Cannabinoid _____	€Hallucinogens _____
	€Cocaine _____	€Controlled Substance Analogs (Designer Drugs) _____
	€Opiate _____	€Other (_____) _____

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MEDICAL RELEASE FORM

☐ I hereby authorize Dr. Jeffrey T. Apter and/or his staff to contact my physician to request information concerning any medical information available regarding my health records.

☐ I also authorize Princeton Medical Institute to send information to my physician regarding my study participation. This will allow my current physician to know the name of the study medication I may be taking, the most common side effects associated with it, and to obtain copies of the laboratory work done at Princeton Medical Institute.

I, the undersigned, hereby authorize and request you to release and/or send my records as indicated below:

Patient Name (Please Print): _____

Patient Signature / Date: _____ / _____

Guardian Signature / Date: _____ / _____
(If patient is a minor)

Physician's Name: _____
Area of Specialty: _____
Address: _____
_____
Phone: _____
Fax: _____

Physician's Name: _____
Area of Specialty: _____
Address: _____
_____
Phone: _____
Fax: _____

PLEASE MAIL / FAX THE REQUESTED INFORMATION TO:

PRINCETON MEDICAL INSTITUTE
WOODLANDS PROFESSIONAL BUILDING
256 BUNN DRIVE, SUITE 6
PRINCETON, NJ 08540
TEL: (609) 921-3555
FAX: (609) 921-3620

☐ Psychological Records	☐ CT of the Head	☐ _____
☐ Medical Records	☐ Chest X-Ray	☐ Records For Period From _____ to _____
☐ Lab Results	☐ EKG	☐ Most Current Records Only