PRINCETON MEDICAL INSTITUTE
NEW PATIENT REGISTRATION

PLEASE PRINT INFORMATION					
Name:				**Date:**	
	First	**Middle**	**Last**		
Date of Birth:				Age:	
Gender:	Male Female	Race:		Hispanic Non-Hispanic	
Currently Employed?	Yes No	Occupation (CURRENT OR PREVIOUS)			
Marital Status:	Married	Divorced	Widowed	Single	

CONTACT INFORMATION		
Primary Phone:	Home Cell Work Other	
Secondary Phone:	Home Cell Work Other	
Email Address:	SSAN:	
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:	

PRINCETON MEDICAL INSTITUTE
NEW PATIENT REGISTRATION

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

PRINCETON MEDICAL INSTITUTE
NEW PATIENT REGISTRATION

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

PRINCETON MEDICAL INSTITUTE
NEW PATIENT REGISTRATION

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, at least, give 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 last date used. Amphetamine Phencyclidine Barbiturate Inhalant Cannabinoid Hallucinogens Cocaine Controlled Substance Analogs (Designer Drugs) Opiate Other		

PRINCETON MEDICAL INSTITUTE

NEW PATIENT REGISTRATION

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

PLEASE MAIL / FAX THE REQUESTED INFORMATION TO:
PRINCETON PSYCHIATRIC CENTER
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