New Patient Packet

Dear Patient and/or Guardian,

Thank you for choosing the Adolescent Medicine Faculty Practice at the Joseph M. Sanzari Children’s Hospital, Hackensack University Medical Center. Your first appointment is scheduled for ________ at _________. We ask that you arrive 20-30 minutes earlier than the scheduled appointment time for registration.

To ensure the best care, we ask that you bring the following with you:

- Physician referral such as a script from your pediatrician or primary care provider for an adolescent medicine consult
- Insurance card
- Insurance referrals if applicable to your insurance plan. Referrals are to be made out to Jennifer Northridge MD, NPI 1003132853. Please call if you have any questions regarding your need for a referral
- The enclosed Adolescent Medicine Interview forms completed and signed

We are located in the WFAN Pediatric Center on the 3rd floor. Parking can be found underneath the WFAN building. Directions are attached.

We look forward to seeing you. If there are any questions, please feel free to call us at (551) 996-2237.

Sincerely,

Adolescent Medicine Care Team
New Patient Interview
Adolescent Medicine, Sanzari Children’s Hospital
Group NPI 121598249
Dr. Jennifer Northridge NPI 1003132853

Patient Information

Today’s Date: _____________
Patient’s Name: _____________________________________________________________
Date of Birth: ___________________ Age: ______
Best phone number to reach patient: ____________________________________________
Best phone number to reach parent/guardian: ____________________________________

Primary Insurance___________________________________________________________
Group #________________________ Name of Policy Holder: _______________________
ID#____________________________

Secondary Insurance (if applicable) ____________________________________________
Group #________________________ Name of Policy Holder: _______________________
ID#____________________________

Preferred pharmacy: _______________________________________________________
Phone: __________________
Contracted Laboratory: ______________________________________________________

Health History

Why was your child referred to our office? _______________________________________
____________________________________________________________________________

Are there any other symptoms/complaints or questions you would like to discuss? _______
____________________________________________________________________________

Who referred our child to our office? ____________________________________________
Address_________________________ Phone: __________________

Primary Care Physician Name (if different than above):___________________________
Address_________________________ Phone: __________________

Names and phone numbers of any other healthcare providers your child (if applicable):
Health Care Provider:__________________ Specialty:____________ Phone:___________
Health Care Provider:__________________ Specialty:____________ Phone:___________
Past Medical History

Do you have any medical problems? Please list: _______________________________________

Have you ever been hospitalized or had a significant illness in the past?____________________

Have you had any type of surgery?: _____________________________________________________

Are you taking any medications? (List both prescription & non-prescription medications and dosages): ______________________________________________________________

Do you have any allergies (food, medications, or environmental): _________________________

Are immunizations up to date? ☐ Yes; ☐ No

Have you received the flu vaccine in the past year? ☐ Yes; ☐ No

Family History

Any family history of hypertension, diabetes, IBD, thyroid disease, eating disorder, depression, other psychiatric illnesses, clotting or bleeding disorder, or irregular periods?

Please list:__________________________________________________________________________

Mother Medical Problems_______________________________________________________________

Father Medical Problems_______________________________________________________________

Siblings Medical Problems_____________________________________________________________

Social History

Mother Name:_________________________________________________________________________

Father Name:_________________________________________________________________________

Who do you live with?_________________________________________________________________

What school do you go to (if applicable)?_______________________________________________ What grade?________

Any special learning needs or problems in school?________________________________________

Approximately how often do you miss school? _____ days/month