PRINCETON PRIMARY & URGENT CARE CENTER
707 Alexander Rd, Ste 201, Princeton, NJ 08540
Tel (609) 919-0009 Fax (609) 919-0008

PATIENT REGISTRATION FORM

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MID INITIAL: ____

SEX: ☐M ☐F MARITAL STATUS: ☐S ☐M ☐W ☐D ☐Sep ☐Partner SS# _____ _____ _____

BIRTHPLACE: _____ DATE OF BIRTH: _____ HOME PHONE: _____

ADDRESS: _____ CELL PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER: _____

EMERGENCY CONTACT INFORMATION RELATIONSHIP TO PATIENT: _____

LAST NAME: _____ FIRST NAME: _____ MID INITIAL: _____

ADDRESS: _____

HOME PHONE:_____CELL PHONE:_____WORK PHONE: _____

PRIMARY INSURANCE INFORMATION RELATIONSHIP TO PATIENT: _____

INSURANCE COMPANY NAME: _____

SUBSCRIBER #: _____ GROUP #: _____ EFF DATE: _____

If dependent, please fill out GUARANTOR INFORMATION below:

LAST NAME: _____ FIRST NAME: _____ MID. INITIAL: ____

SEX: ☐M ☐F DATE OF BIRTH: _____ SS#: _____ _____ _____

ADDRESS: _____

HOME PHONE:_____CELL PHONE:_____WORK PHONE: _____

SECONDARY INSURANCE INFORMATION RELATIONSHIP TO PATIENT: _____

INSURANCE COMPANY NAME: _____

SUBSCRIBER #: _____ GROUP #: _____ EFF DATE: _____

If dependent, please fill out GUARANTOR INFORMATION below:

LAST NAME: _____ FIRST NAME: _____ MID. INITIAL: ____

SEX: ☐M ☐F DATE OF BIRTH: _____ SS#: _____ _____ _____

ADDRESS: _____

HOME PHONE:_____CELL PHONE:_____WORK PHONE: _____

MEDICATIONS/ALLERGIES Are you allergic to **ANY** medications: ☐Yes ☐No; *if **Yes**, specify below*

Drug Name	*Dose*	*Drug Name*	*Dose*
_____		_____	
_____		_____	
_____		_____	

ALLERGIES TO MEDICATIONS: _____

PRIOR SURGERIES: *DATE*:

_____ _____

_____ _____

_____ _____

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS: *(Circle if you had problems with or are presently complaining of any of the ff:*

1. High blood pressure	13. Bronchitis	25. Ulcers	37. Difficulty urinating
2. Diabetes	14. Pneumonia	26. Change in bowel habits	38. Arthritis
3. Cancer	15. Persistent Cough	27. Unexplained weight gain/loss	39. Low back problems
4. Heart Disease	16. TB	28. Hemorrhoids	40. Skin disease
5. Chest Pain/Tightness	17. Hay Fever	29. Gall bladder disease	41. Blood disorders
6. Shortness of Breath	18. Abdominal Discomfort	30. Colitis	42. Venereal diseases
7. Swollen Ankles	19. Indigestion	31. Hepatitis or jaundice	43. Anxiety
8. Palpitations	20. Nausea	32. Thyroid disease	44. Depression
9. Light-headedness	21. Vomiting	33. Head or neck radiation	45. Anemia
10. Frequent Urination	22. Constipation	34. Headache	46. Alcohol abuse
11. Rheumatic Fever	23. Diarrhea	35. Kidney disease	47. Drug abuse
12. Asthma	24. Blood in stool	36. Kidney stones	48. Gout

Others: _____

GYNECOLOGIC & OBSTETRIC HISTORY (*Women Only*)

Periods: *Age at Onset:*_____ *Frequency:* _____ *Length of Periods:* _____

Pregnancies: *Total:* _____ *Births:* _____ *Miscarriages:* _____

When was your last: *Pap Smear:* _____ *Mammogram:* _____ *Breast Exam:* _____

Any significant Gyn History: _____

SMOKING & ALCOHOL USE

Have you ever smoked? ☐Yes ☐No # of Years: _____ Packs/Day: _____ If you Quit, When? _____

Alcohol Consumption: ☐None ☐Social ☐Moderate ☐Heavy Frequency: ☐Daily ☐Weekly

I hereby authorize PPUCC to furnish information to insurance carriers concerning my illness and treatment and hereby assign to these physicians all payments for medical services rendered to my dependent or myself. I understand that regardless of my insurance coverage, I am ultimately responsible for charges provided by PPUCC.

Signature: _____ **Date**: _____