



## **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.**
- > **Fax recent blood work and growth chart before the appointment to 551-996-0734.**
- > **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 3<sup>rd</sup> 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



Hackensack  
Meridian Health  
Joseph M. Sanzari  
Children's Hospital

## 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 \_\_\_\_\_ ID#

Group # \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_

Secondary Insurance (if applicable) \_\_\_\_\_ ID#

Group # \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_

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 health care providers your child (if applicable):

Health Care Provider: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Care Provider: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

Psychiatrist: \_\_\_\_\_ Phone:

Psychologist/Therapist: \_\_\_\_\_ Phone:  
Nutritionist: \_\_\_\_\_ Phone:



Hackensack  
Meridian Health  
Joseph M. Sanzari  
Children's Hospital

### 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