Hackensack Meridian *Health*
Joseph M. Sanzari Children's Hospital

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 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 _____ 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:

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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