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:
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