(Please Print)

PATIENT REGISTRATION FORM

Plainsboro Medical Associates, P.A.

Xiaomei Chen, M.D.

Pharmacy: _____

Pharmacy Phone: (___)_____

PATIENT INFORMATION

Name: _____ SSN: _____-_____-_____ Home Phone: (___) _____
Last First Middle

Cell Phone: (___)_____ E-mail Address: _____

Home Address: _____
Street City State Zip Code

Sex: □ Male □ Female Date of Birth: _____/_____/_____ Marital Status: □ Single □ Married □ Divorced □ Widowed

Ethnicity: _____ Hispanic or Latino: □ Yes □ No

Company Name: _____ Business Phone: (___)_____ Ext. _____

Business Address: _____
Street City State Zip Code

Spouse Name: _____ Business Phone: (___)_____ Ext. _____

In Case of Emergency Contact Person: _____ Relation to Patient: _____ Phone: (___) _____

Who should we thank for referring you? _____ Phone: (___) _____

PRIMARY INSURANCE

Insurance Company: _____ ID #: _____ Group #: _____

Insured's Name: _____ Home Phone: (___)_____
Last First Middle

Sex: □ Male □ Female SSN: _____-_____-_____ Date of Birth: _____/_____/_____ Relation to Patient: _____

Address (if different from patient's): _____
Street City State Zip Code

Insured's Company Name : _____ Business Phone: (___) _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? □ Yes □ No (If 'Yes', please fill out the following information)

Insurance Company: _____ ID #: _____ Group #: _____

Insured's Name: _____ Home Phone: (___)_____
Last First Middle

Sex: □ Male □ Female SSN: _____-_____-_____ Date of Birth: _____/_____/_____ Relation to Patient: _____

Address (if different from patient's): _____
Street City State Zip Code

Insured's Company Name : _____ Business Phone: (___) _____

ASSIGNMENT AND RELEASE

I understand that I am financially responsible for all services rendered whether or not paid for by insurance. If a referral form is required by my insurance for a service and I neglect to secure it, I am financially responsible for the service provided. I authorize the release of medical information necessary to process claim forms.

Patient's Signature: _____ Date: _____

Plainsboro Medical Associates, P.A.
Xiaomei Chen, M.D.

Name _____ Sex _____ DOB _____ / _____ / _____ Date _____

Reason for Visit _____

Drug Allergies

_____

_____

_____

Current Medications (& non-prescription medicine)

_____

_____

_____

_____

_____

_____

_____

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy / Convulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

Hospitalization or Surgery

Reason	Date	Reason	Date
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Women Only Pregnant? ☐ Yes ☐ No Planning Pregnancy? ☐ Yes ☐ No 1st day of last period ____/____ / ____

Medical History

☐ Hypertension _____	☐ Anxiety / Depression _____	☐ Sexual Dysfunction _____
☐ Hyperlipidemia _____	☐ Fatigue _____	☐ Menstrual Dysfunction _____
☐ Heart Palpitations _____	☐ Shortness of Breath _____	☐ Incontinence _____
☐ Heart Murmur _____	☐ Orthopnea _____	☐ Anemia _____
☐ Arrhythmia _____	☐ Allergies / Hay Fever _____	☐ Arthritis _____
☐ Chest Pain / Angina _____	☐ Asthma _____	☐ Osteoporosis _____
☐ MI _____	☐ COPD _____	☐ Gout _____
☐ Stroke / TIAs _____	☐ Pneumonia _____	☐ Diabetes _____
☐ Claudication _____	☐ Venereal Disease _____	☐ Endocrine Disease _____
☐ Congestive Heart Failure _____	☐ TB _____	☐ Hepatitis B / C _____
☐ Congenital Heart Disease _____	☐ Rheumatic Fever _____	☐ HIV _____
☐ Headache _____	☐ Liver Disease _____	☐ Cancer _____
☐ Epilepsy _____	☐ Ulcer _____	☐ Other _____
☐ Dizziness / Fainting _____	☐ GI Disorder _____	☐ Other _____

Habits

☐ Smoke: Packs Daily _____	☐ Coffee: Cups Daily _____	☐ Diet: Salt Intake _____
How Long? _____	Other Caffeine _____	Fat Intake _____
☐ Drugs? _____	☐ Alcohol: Type _____	☐ Exercise Routine: _____
Please add any additional information on the back of the page if necessary	Amount _____	_____

Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES*

**You May Refuse To Sign This Acknowledgement.*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
[Please Print Name]

_____
[Signature]

_____
[Date]

To whom do we have your permission to release your medical information to?

Please provide full name, date of birth (for verification purposes) and specify contact information for any method by which they may receive such information, i.e. Phone (Voice/Text), Email, Fax, WeChat, Other (please specify).

1) Name:_____ DOB: ___/___/_____

☐Phone:_____(circle **Voice** and/or **Text**)

☐Email:_____

☐Fax:_____ ☐WeChat:_____

☐Other

(Specify):_____

2) Name:_____ DOB: ___/___/_____

☐Phone:_____(circle **Voice** and/or **Text**)

☐Email:_____

☐Fax:_____ ☐WeChat:_____

☐Other

(Specify):_____

OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of our **Notice of Privacy Practices**, but acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communications barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining the acknowledgement
☐ Other (Specify):_____

New Jersey Department of Health
Vaccine Preventable Disease Program
P.O. Box 369, Trenton, NJ 08625-0369
609-826-4860 (Fax 609-826-4866)
www.njiis.nj.gov

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)
CONSENT TO PARTICIPATE

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD –

REGISTRANT INFORMATION	***PARENT GUARDIAN INFORMATION (If NJIIS Registrant is a Minor)***
Registrant Name *(Print)*	Name *(Print)*
Date of Birth (Before 1/1/98)	Address (Street)
Country of Birth	(City, State, Zip Code)
Name of Primary Health Care Provider **Dr. Xiaomei Chen**	Relationship to Registrant

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history.

I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3.

I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH may be contacted at the website or telephone number listed above.

There is no cost to participate in this program.

☐ Yes, I would like to participate in this program.

☐ No, I do not want to participate in this program.

Signature of Registrant (or Parent/Guardian, IF Registrant is Under 18 Years of Age)	Date

Name of NJIIS Enrollment Site	Registry ID Number	Medical Record Number
Plainsboro Medical Associates		

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD –