Princeton Medical Group PA
419 North Harrison Street
Princeton, NJ 08540-3594
(609) 924-9300

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS ☐ Full-Time ☐ Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#
NAME OF INSURED	GROUP#
ADDRESS OF INSURANCE COMPANY	COPAY AMT $
CITY, STATE ZIP / PHONE	DEDUCTIBLE $
RELATIONSHIP TO PATIENT	EFFECTIVE DATE / EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY	POLICY#
NAME OF INSURED	GROUP#
ADDRESS OF INSURANCE COMPANY	COPAY AMT $
CITY, STATE ZIP / PHONE	DEDUCTIBLE $
RELATIONSHIP TO PATIENT	EFFECTIVE DATE / EXPIRATION DATE

I have completed this form and certify that I am the patient, or duly authorized agent of the patient. I understand that, even though I have insurance coverage I am responsible for payment on the date of service. I authorize release of medical information as may be required to substantiate or explain insurance claims filed. I permit a copy of this authorization to be used in place of the orignial. This authorization will remain in effect until revoked by me in writing. I authorize my insurance company to assign benefits to Princeton Medical Group, PA. Under HIPAA Payment, Treatment and Options (TPO) I give permission to Princeton Medical Group to access Pharmacy Benefit Manager Information for management of prescriptions.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

Race, Ethnicity and Language / Standardization for Health Care Quality Improvement:

Patient Name: _____ **Date of Birth:** _____

The U.S. Department of Health and Human Services (HHS) Disparities Action Plan builds upon the Affordable Care Act and the American Recovery and Reinvestment Act. The Affordable Care Act not only includes provisions related broadly to health insurance coverage, health insurance reform, and access to care, but also provisions related to disparities reduction, data collection and reporting, quality improvement, and prevention.

Section 4302 of the Affordable Care Act contains provisions to strengthen federal data collection efforts by requiring that all federally funded programs to also collect data on race, ethnicity and primary language. Under the "meaningful use" incentive program we are asked to collect this data.

Please review, circle one selection from each section and submit this form back to the check-in staff. Use the "Unknown/Not Reported" or "Declined to Specify" option if you prefer not to give this information.

Race

- o American Indian or Alaska Native
- o Asian
- o Black or African American
- o Multiracial
- o Native Hawaiian or Other Pacific Islander
- o White
- o Declined to Specify

Preferred Language

- o Arabic
- o Bulgarian
- o Central Khmer
- o Chinese
- o English
- o French
- o German
- o Haitian, Haitian Creole
- o Hebrew
- o Hindi
- o Italian
- o Japanese
- o Korean
- o Polish
- o Portuguese
- o Russian
- o Somali
- o Spanish
- o Spanish, Castilian
- o Swahili
- o Thai
- o Urdu
- o Vietnamese
- o Other
- o Declined to Specify

Ethnicity

- o Hispanic or Latino
- o Not Hispanic or Latino
- o Declined to Specify
- o Unknown/Not Reported

3/31/2014