PRINCETON PHYSICIANS GROUP, P.C.

88 ROUTE 571, STE 201

WEST WINDSOR, NJ 08550

PHONE: 609-799-0100 FAX: 609-799-2832

Last Name:	Birthdate:
First Name: Middle Initial	Married ? YES or NO
Maiden Name: Female Male	Social Security Number:
Mailing Address Line 1:	Employed ? YES or NO
Mailing Address Line 2:	Employer Name:
City:	Student ? YES or NO
State: Zip Code:	
Home Phone # :	Email Address:
Work Phone # :	Race: Language:
Cell Phone # :	Ethnicity:

EMERGENCY CONTACT

Name:	Pharmacy Name/Phone Number:
Relationship:	Pharmacy Address:
Phone:	
Phone:	

Is it allowable to leave a message regarding test results or appointments with the following:

Home ____ Cell ____ Family Member YES or NO

I have read and fully understand the above consent for treatment. I understand that payment for services rendered is due at the time of service unless previous arrangements have been made via an insurance carrier or payment plan.

I agree to pay all reasonable collection costs in the event of default of payment. This includes a 35% collection fee plus 7% interest. I understand that any balances outstanding after 90 days due to my failure to submit requested information carrier or due to my providing this office with correct insurance information including but not limited to coordination of benefits or ID cards will become my responsibility and payable by me.

Patient Signature: ____ Date: ______________________