Department of Obstetrics and Gynecology
833 Chestnut Street, 1st Floor
Philadelphia, PA 19107
T 215-955-5000

Thank you for choosing Jefferson Obstetrics and Gynecology for your care. Our office is located at:
833 Chestnut Street, 1st Floor, Philadelphia, PA 19107 • 215-955-5000

Please note: The entrance to the building is on Chestnut Street closer to 8th Street.

In order to provide you with the best possible care, we ask for your cooperation in completing several forms prior to your first visit. Enclosed you will find a patient registration form and medical history questionnaire. Please complete these and bring them with you to your first appointment, ***please do not mail completed forms to the office***. If you are coming in for a consultation or second opinion, you should bring any pertinent operative records and laboratory records related to your condition. We are an academic medical center and you may interact with some of our residents and medical students during your visit.

At each office visit, our receptionist will ask you to review your registration information and verify that it is correct. We ask that you bring your insurance card and a form of identification with you to every visit. We also encourage you to sign up for Jefferson My Health: a secure and convenient way to manage your personal health and communicate directly with your participating healthcare team. You will be provided the opportunity to sign up for an invitation upon registration. Please be prepared to pay any co-pay that is your responsibility or to provide us with a referral upon arrival.

If you are unable to keep your appointment, we ask that you call our office within 24 hours so that we may offer this appointment to another patient.

You have scheduled an appointment with:

Provider: _____

Date of Appointment: _____

Time of Appointment: _____

We recommend arriving to the office 15 minutes early to allow for the registration process. Please be advised, we allow a **15 minute grace period** for tardiness to your appointment. In order to be respectful of all our patients' time, if you arrive more than 15 minutes after your scheduled appointment time, you **will be** asked to reschedule your appointment.

Sincerely,

The Physicians and Nurse Practitioners of Jefferson Obstetrics and Gynecology

Directions and Parking Discounts to Jefferson

Department of Obstetrics and Gynecology
833 Chestnut Street
Philadelphia, PA 19107
215-955-5000

From the Pennsylvania Turnpike

Exit at Valley Forge. Take Rt. 76 East to I-676 East to the 8th Street/Chinatown Exit. Take 8th Street cross Market Street to Central PARK Garage (on Left) immediately after Ranstead Street.

From I-95 North of Wilmington

Take Exit 22 Independence Hall/Callowhill Street, following signs for Callowhill Street. Proceed on Callowhill to 8th Street (south). Turn left onto 8th. Take 8th Street cross Market Street to Central PARK Garage (on Left) immediately after Ranstead Street.

From I-95 South (from Bucks County)

Take Exit 22 Independence Hall/Callowhill Street, following signs for Callowhill Street. Proceed on Callowhill to 8th Street (south). Turn left onto 8th. Take 8th Street cross Market Street to Central PARK Garage (on Left) immediately after Ranstead Street.

From New Jersey Shore Points

Take the Atlantic City Expressway North to Rt. 42 North. Follow signs for the Benjamin Franklin Bridge (toll). Get into the extreme LEFT lane and follow signs for 8thStreet/Chinatown. Turn left onto 8th. Take 8th Street cross Market Street to Central PARK Garage (on Left) immediately after Ranstead Street.

From New York and north New Jersey

Take the New Jersey Turnpike South to Exit 4 / Rt. 73 North. Take Rt. 73 North to Rt. 38 West. Follow Rt. 38 West to the Benjamin Franklin Bridge. Cross over the Benjamin Franklin Bridge (toll). Get into the extreme LEFT lane and follow signs for 8th Street/Chinatown. Turn left onto 8th. Take 8th Street cross Market Street to Central PARK Garage (on Left) immediately after Ranstead Street.

From Central PARK Garage to office:

Walk on Chestnut Street towards 8th, cross 8th and the OB/Gyn office is approx. 1/8 block from 8th Street corner. Entrance is under ornamental gold overhang.

PARKING AREAS

Please ask the front desk for a stamp/coupon to validate for discounts

Central Park Garage – enter from 8th or Chestnut Street (discounted parking coupon)

Ben Franklin Parking (underground-located at the Ben Franklin) – enter Sansom Street between 8th and 9th Streets ($14. Per day)

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CS 15-0390

Center City Campus Map

and the new home of Jefferson's Ob/Gyn Department

Department of Obstetrics and Gynecology
833 Chestnut Street
Philadelphia, PA 19107
215-955-5000

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CS 15-0390

JUP Patient Registration Form

Jefferson™

Today's Date:

Please complete this form in order to ensure proper billing of your services. **Please Print.**

Patient's Last Name			Patient's First Name	MI
DOB / /	Sex ☐ M ☐ F	Social Security Number — —	Language ☐ English ☐ Other _____	
Race ☐ African American or Black ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Caucasian or White ☐ Unknown ☐ Declined				
Ethnicity ☐ Hispanic or Latino ☐ Not-Hispanic or Non-Latino ☐ Unknown ☐ Declined				
Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other _____				
Address Line 1			Address Line 2	
City			State	Zip
Home Phone		Preferred Phone	Cell Phone	
Home E-mail				
Emp Status ☐ Employed Full Time ☐ Employed Part Time ☐ Self-Employed ☐ Unemployed ☐ Disabled ☐ Active Military ☐ Homemaker ☐ Student Full Time ☐ Student Part Time ☐ Other _____				
Employer			Work Phone	
Employer's Address Line 1			Employer's Address Line 2	
City			State	Zip

Please complete if guarantor is other than self. *(Guarantor is the person financially responsible for this patient's bill.)*

Guarantor's Last Name			Guarantor's First Name	MI
DOB / /	Sex ☐ M ☐ F	Social Security Number — —	Patient's Relationship to the Guarantor	Guarantor's Home Phone
Guarantor's Address Line 1		Guarantor's Address Line 2		Guarantor's Work Phone
City			State	Zip
Guarantor's Employer				
Guarantor Employer's Address Line 1			Guarantor Employer's Address Line 2	
City			State	Zip

Emergency Contact Information

Emergency Contact's Last Name		Emergency Contact's First Name	MI
Patient's Relationship to the Emergency Contact	Primary Phone	Secondary Phone	

Please select the source in which you heard of our practice

☐ Billboard ☐ Brochure ☐ Health Fair ☐ Health Plan ☐ Internet ☐ JEFF NOW® ☐ Mass Mailing ☐ Newspaper/Mag. ☐ Ongoing Care
☐ Patient ☐ Phone Book ☐ Phys. Off./ER ☐ Relative ☐ Radio ☐ TV ☐ Word of Mouth ☐ Other _____

Insurance Information *A separate form is required for workers' compensation, automobile liability, or legal services.*

Primary Insurance Company Name			
Subscriber's Last Name	Subscriber's First Name	Subscriber's DOB / /	Patient's Relationship to the Subscriber
Subscriber's Last 4 digits of SS#	Subscriber's Employer		
Secondary Insurance Company Name			
Subscriber's Last Name	Subscriber's First Name	Subscriber's DOB / /	Patient's Relationship to the Subscriber
Subscriber's Last 4 digits of SS#	Subscriber's Employer		

Communication of Protected Health Information

I would like Jefferson University Physicians ("Jefferson") to share my protected health information, which includes billing information, with the individuals (e.g., my spouse, parent(s), etc.) listed below.

After providing Jefferson with this completed and signed form, Jefferson agrees to communicate with the individuals listed below unless I provide Jefferson with written notice to no longer do so.

I. Patient Identification

Patient Name: _____ Date of Birth: _____

II. Authorization of Communication

I hereby grant Jefferson's Department/Division of _____ permission to communicate my protected health information to the following individuals:

Name:	Patient Relationship:
Address:	Phone Number(s):

Name:	Patient Relationship:
Address:	Phone Number(s):

Name:	Patient Relationship:
Address:	Phone Number(s):

Name:	Patient Relationship:
Address:	Phone Number(s):

Name:	Patient Relationship:
Address:	Phone Number(s):

Name:	Patient Relationship:
Address:	Phone Number(s):

I understand that completing this form is voluntary. I am not required to list any individuals.

Patient Signature: _____ **Date:** _____

Witness: _____ Date: _____

Jefferson

JUP Patient Profile Form

Patient Name: _____ **Date of Birth:** _____
(Please Print)

MRN: _____

Associated Providers

Please list any physicians below who should receive information regarding your care/visit.

Primary Care Provider

Name: _____ Specialty: _____

Address: _____

City, State: _____ Zip: _____

Phone: _____ Fax: _____

Referring Provider

Name: _____ Specialty: _____

Address: _____

City, State: _____ Zip: _____

Phone: _____ Fax: _____

Pharmacy Information

Please complete your pharmacy information below.

Retail Pharmacy

Name: _____

Address: _____

City, State: _____ Zip: _____

Phone: _____ Fax: _____

Mail Order Pharmacy

Name: _____

Address: _____

City, State: _____ Zip: _____

Phone: _____ Fax: _____

Laboratory/Radiology Information

Are your laboratory and radiology studies capitated to a specific performing location? ☐ Y ☐ N

Laboratory: _____ Radiology: _____

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JUP Medical History Questionnaire

MRN # _____

Patient Name *(Please Print)*: _____ Date of Birth: _____

Provider you are seeing today: _____ Today's Date: _____

Please state your problem in your own words as to why you are here today: _____

_____

_____

Did a physician request that you see one of our providers today? ☐ Yes ☐ No If yes, name of physician: _____

Past Medical History *(check all that apply)*: ☐ **No Past Medical History**

- ☐ Acute Myocardial Infarction (Heart Attack)
- ☐ Anemia (Low Blood Count)
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disorder (Lupus/Scleroderma/RA)
- ☐ Blood Transfusion Complications
- ☐ Cancer - list type(s):
  - _____
  - _____
  - _____
- ☐ Chest Pain (Angina)
- ☐ Chronic Liver Disease
- ☐ COPD (Chronic Obstructive Pulmonary Disease)
- ☐ Diabetes Mellitus
- ☐ Emotional Disturbance
- ☐ Gastric/Duodenal Ulcer
- ☐ Heart Disease
- ☐ Heartburn
- ☐ Hepatic (Liver) Disorder
- ☐ Hepatitis
- ☐ HIV Infection
- ☐ Hypercholesterolemia
- ☐ Hypertension
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Lower Back Pain
- ☐ Mitral Valve Disorder
- ☐ Murmurs
- ☐ Obesity
- ☐ Obstructive Sleep Apnea
- ☐ Osteoporosis
- ☐ Peripheral Vascular Disease (Poor Circulation)
- ☐ Pneumonia
- ☐ Pulmonary Disease (Lung Disease)
- ☐ Recent Methicillin-resistant Staph aureus (MRSA)
- ☐ Rheumatic Fever
- ☐ Seizure Disorder
- ☐ Sinusitis
- ☐ Stroke Syndrome
- ☐ Thromboembolic Disease (Blood Clot Disorder)
- ☐ Thrombophlebitis
- ☐ Thyroid Disorder
- ☐ Transient Ischemic Attack (Mini Stroke)
- ☐ Tuberculosis
- ☐ Other (specify):
  - _____
  - _____
  - _____

Surgery: ☐ **No Surgical History**

Surgery	Date	Surgery	Date

Family History *(check all that apply)*: ☐ **No Family Medical History**

	Family Member*		Family Member*
☐ Anemia (Low Blood Count)		☐ Hypercholesterolemia	
☐ Cancer - list type(s):		☐ Hypertension	
		☐ Osteoporosis	
		☐ Pulmonary Disease	
☐ COPD		☐ Renal Disease	
☐ Diabetes Mellitus		☐ Stroke Syndrome	
☐ Emphysema		☐ Thromboembolic Disease	
☐ Heart Disease		☐ Unattainable-Patient Adopted	
☐ Hepatic (Liver) Disorder		☐ Other:	
Family Health Status of Father – Deceased Age:		Cause:	
Family Health Status of Mother – Deceased Age:		Cause:	

Please indicate the family member affected: mother, father, brother, sister, maternal or paternal grandmother/grandfather, etc.

 MRN # _____

Patient Name: _____ Date of Birth: _____

Social History:

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced ☐ Life Partner

(check all that apply)

☐ **Alcohol Use:** Weekly: _____

☐ **Drug Use (Recreational):** Explain: _____

☐ **Using Intravenous Drugs:** Explain: _____

☐ **Previous History of Smoking:** Date Quit: _____ Packs Per Day _____ Years of Smoking: _____

Attempts to Quit: _____ Methods Used to Quit: _____

☐ **No History of Smoking** ☐ **Wishing to Stop Smoking**

☐ **Smoking/Nicotine Substances:** ☐ Cigarettes: Packs/Times Per Day: _____ Years _____

☐ Cigars ☐ Chewing ☐ Tobacco ☐ Pipe

☐ **Current Diet:** Explain: _____

☐ **Exercise Habits:** Times per week: _____ ☐ **Being Sedentary** (Do not exercise) ☐ **Sexually Active**

☐ **Occupation:** List All: _____

☐ **Travel:** If recently out of the country, where? _____

Do you have an advanced directive? ☐ Yes ☐ No

Allergies: ☐ **No Known Allergies**

Allergy	Reaction	Allergy	Reaction

Medications (Include vitamins, herbal supplements and over the counter medications): ☐ **No Current Medications**

Medications	Dosage	Frequency	Reason for Taking

Have you participated in any clinical trials or used experimental drugs? ☐ Yes ☐ No Explain: _____

Are you pregnant? ☐ Yes ☐ No Last Menstrual Period Date: _____

Is there anything else about your medical history that we should know? _____

Patient Signature: _____ **Date:** _____

I certify that I have reviewed the above information with the patient.

Physician Signature: _____ **Date:** _____

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Obstetrics and Gynecology
Supplemental Medical History Questionnaire

MRN # _____

Patient Name *(Please Print)*: _____ Date of Birth: _____

Provider you are seeing today: _____ Today's Date: _____

Names of any specialists you are seeing, not including your primary care provider/family physician:

_____

_____

_____

For all items in this questionnaire, please feel free to leave any item blank and discuss directly with your care provider. This form may be scanned into your confidential electronic medical record.

Pregnancy History

Year of Preg.	Miscarriage (✔)	Abortion (✔)	Ectopic Pregnancy (✔)	Vaginal Delivery (✔)	Cesarean Delivery (✔)	Weight of Baby	Weeks Pregnant at Delivery	Problems/Complications

Personal History (check all that apply)

Now or in the past, have you ever had:

☐ Hormonal problems, abnormal hair growth	☐ Any type of excessive bleeding, vaginal or other
☐ Problems with leaking urine	☐ Pain or bleeding with urination
☐ Stomach or bowel pain or problems	☐ Breast problems (lumps, tumors, cysts, discharge)
☐ A mammogram; Date of most recent:	☐ Vaginal infections/discharge
☐ Sexually transmitted diseases	☐ Ovarian cysts
☐ Fibroids	☐ Abnormal Pap smear
☐ Any kind of abusive relationship	☐ Pain or bleeding with sex
☐ Emotional illness	☐ Severe pain or emotional problem with periods
☐ Infertility	☐ Problems/complications with anesthesia
☐ Religious objections to blood transfusion or any other medical treatment	☐ Any objection to routine HIV testing

 MRN # _____

Patient Name: _____ Date of Birth: _____

Sexual and Contraceptive History

Age at first intercourse: _____ No. of partners since first intercourse: _____ No. of partners last year: _____

Partners: ☐ Male ☐ Female ☐ Both

Are you using birth control now: ☐ Yes ☐ No

Are you satisfied with your current contraceptive method: ☐ Yes ☐ No

If you want birth control, what method do you want? _____

Do you plan children in the future? ☐ Yes ☐ No ☐ Undecided

Do you have any questions about sex you'd like to discuss? ☐ Yes ☐ No

Are you interested in HIV testing/information? ☐ Yes ☐ No

Would you like to be tested for STD's (gonorrhea, chlamydia, syphilis, hepatitis, herpes, HIV)? ☐ Yes ☐ No

Please tell us about any methods of birth control you or your partner are now using or have used in the past, and any problems you have had with them:

Pap Smear and Menstrual History

When did you have your last Pap smear? _____ Was it normal? ☐ Yes ☐ No

If not, what further testing or treatment did you have?

Age at first menstrual period: _____ First day of last menstrual period: _____

Periods come every _____ days. Number of days of flow: _____ Periods are: ☐ Light ☐ Moderate ☐ Heavy

Was your last menstrual period normal? ☐ Yes ☐ No

Do you ever miss periods? ☐ Yes ☐ No

Do you ever bleed between periods? ☐ Yes ☐ No

Do you think you may be pregnant now? ☐ Yes ☐ No ☐ Not sure

Do you take medicine for painful periods? ☐ Yes ☐ No Name of medicine: _____

If you are menopausal, have you had any bleeding since menopause? ☐ Yes ☐ No

Are you having severe symptoms of menopause? ☐ Yes ☐ No

Please provide any additional information that you want us to have:

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HIV Testing Questionnaire

Name (Please Print) _____

1. Have you ever had a blood transfusion?	☐ Yes ☐ No
If yes, was it before or after 1985?	☐ Before ☐ After
2. Have you ever been treated for a sexually transmitted disease? (gonorrhea, chlamydia, syphilis)	☐ Yes ☐ No
3. Have you ever used street drugs by injection? (shooting up)?	☐ Yes ☐ No
4. Have you had sexual relations with a partner who ever had a blood transfusion?	☐ Yes ☐ No ☐ Don't Know
5. Have you had sexual relations with a partner who ever used drugs by injection?	☐ Yes ☐ No ☐ Don't Know
6. Have you ever had sexual relations with a man who ever had sex with other men?	☐ Yes ☐ No Don't Know
7. Have you ever had sexual relations with a partner who might have been at high-risk for HIV?	☐ Yes ☐ No ☐ Don't Know
8. Do you think that you are at risk at all for being HIV infected?	☐ Yes ☐ No

Please check one of the following:

☐ I would like to be HIV tested.

☐ I need to think more about HIV testing.

☐ I do not want to be HIV tested.

☐ I would like to meet formally with an HIV educator before deciding.

☐ I have chosen not to complete this questionnaire.

Signature _____ Date _____

Jefferson

Department of Obstetrics and Gynecology
833 Chestnut Street, 1st Floor
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January 22, 2013

Dear Patient,

Please be advised that effective January 1, 2012, Jefferson University Physicians began charging a fee to patients that request a copy of their medical records. The fees below are the 2013 allowable amounts approved by the State of Pennsylvania. Please note that the fees are updates annually and are subject to change.

- $1.42 per page for the first 20 pages
- $1.05 per page for pages 21-60
- $0.42 per page for pages over 61

Actual postage amounts will also be charged for the mailing of records.

Just as a reminder, a completed JUP medical records release form must be on file.

If you have any questions please contact Jefferson University Physicians Central Medical Records at 215-503-8768.

Jefferson OB/GYN will be glad to help you with the completion of various forms, which may be necessary to assist you with your healthcare.

Examples of these forms are:

- Disability Forms
- FMLA Forms
- Insurance Forms

Please be advised: You will be charged a $10.00 fee for each form that is submitted to our office for completion. This fee is **not** covered by insurance and is completely separate from any co-pay or coinsurance. Payment will be expected prior to your receipt of the completed form(s).

You will have the option to pay with cash or a check.

We appreciate your understanding and thank you in advance for your cooperation.

Sincerely,

Jefferson OB/GYN