Jefferson University Physicians

JUP Patient Registration Form

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 ☐ Non-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	Daytime Phone		Cell Phone	
Home E-mail				
Emp Status ☐ Employed Full Time ☐ Employed Part Time ☐ Self-Employed ☐ Unemployed ☐ Active Military ☐ Disabled ☐ Homemaker ☐ Student ☐ 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	Home Phone
Guarantor's Address Line 1			Guarantor's Address Line 2	
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	Daytime Phone	Cell 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		

Jefferson University Physicians

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:** _____

Name of Patient _____ Date of Birth _____

In order to assure that your care is coordinated with all of your physicians, please provide us with the names, addresses and/or phone numbers of those physicians.

REFERRING DOCTOR

Name _____

Address _____

Phone _____

PRIMARY PHYSICIAN

Name _____

Address _____

Phone _____

CARDIOLOGIST

Name _____

Address _____

Phone _____

PULMONOLOGIST

Name _____

Address _____

Phone _____

OTHER

Name _____

Specialty _____

Address _____

Phone _____

OTHER

Name _____

Specialty _____

Address _____

Phone _____

PHARMACY INFORMATION

*****Please bring your pharmacy/prescription benefit card with you to your appointment*****

Pharmacy Plan / Benefit Information

_____

_____

_____

Retail Pharmacy Name / Location (ie. CVS, Walgreens, etc.)

_____

_____

_____

Mail Order Company (ie. Caremark, Medco, etc.)

_____

_____

_____

Jefferson University Physicians

JUP Communication of Protected Health Information

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

MRN: _____

Part A

You have informed Jefferson University Physicians (JUP) that in certain circumstances, you would like us to share your medical information with specified individuals (e.g., your spouse, mother, etc.).

JUP agrees to communicate with persons whom you designate regarding your protected health information. This agreement will remain in effect unless you provide us with written notice to terminate this consent.

Part B

I hereby grant Jefferson University Physician's department/division of

_____

permission to communicate my protected health information to the following individuals:

Name:	Relationship:
Address:	Telephone #:

Name:	Relationship:
Address:	Telephone #:

Name:	Relationship:
Address:	Telephone #:

Name:	Relationship:
Address:	Telephone #:

Patient Signature: _____ Date: _____

Witness: _____ Date: _____