Jefferson University Physicians

Department of Dermatology
and Cutaneous Biology
Jefferson Dermatology Associates

T 215.955.6680 F 215.503.3333

Dear_____ Date: _____

Welcome to Jefferson University Physicians Department of Dermatology and Thank You for selecting our practice for your patient care. This will serve as a confirmation of your scheduled appointment with:

*Dr.*_____

Month/Date/Year at Time:_____

Office Location: *833 Chestnut Street, Suite 740 Philadelphia, PA 19107*

We ask that you arrive 15 minutes prior to your scheduled visit. Should you need to cancel and re-schedule your visit for any reason, we require 48 hours prior to your scheduled appointment for another day and time.

To best prepare for your visit kindly make sure to bring the following items with you:

- *Insurance card*
- *Referral form. If your insurance requires you to have a referral please present this when you check in at our office.* ***If you do not bring a referral you will be asked to reschedule your appointment****. Please remember this is a requirement imposed by your insurance carrier.*
- *Request for consultation by your referring physician (if applicable)*
- *Photo ID – this is a requirement of federal regulations.* ***Photo ID will be copied into your chart for your protection.***
- *Payment for services – cash, check or credit card (Visa, Master Card, Discover and ATM card****). Please note that co-payments are contractually required and must be paid at the time of the visit.***
- ***If you are having procedures of a purely cosmetic nature, which will not be covered by your health care insurance, please remember that you will be responsible of payment at the time of service.***

If you have questions about payment policies and procedures, or if you have uncertainty about the terms of your insurance coverage, please feel free to contact one of our billing representatives at 215-503-3796.

Enclosed are several documents that you will need to complete in advance of your visit. ***PLEASE DO NOT MAIL THESE FORMS BACK TO THE OFFICE****. Completing these forms prior to your office visit will ensure that your scheduled appointment time with your provider is not further delayed.*

**Discount parking is located at 800 Market Street, Philadelphia, PA 1910, entrance located at 8 South 8th street and 11 South 9th street. Discounts will only be honored up until 3hours after 3hours the full price will be charged.*

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 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: _____

Jefferson University Physicians

Department of Dermatology

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

☐ Anemia (Low Blood Count)
☐ Arthritis
☐ Asthma
☐ Autoimmune Disorder (Lupus/Scleroderma/RA)
☐ Blood Transfusion Complications
☐ Cancer - list type(s):
_____
_____
_____
☐ Chest Pain (Angina)
☐ COPD (Chronic Obstructive Pulmonary Disease)
☐ Diabetes Mellitus
☐ Emotional Disturbance
☐ Eczema
☐ Gastric/Duodenal Ulcer
☐ Heart Disease/Heart Attack
☐ Heartburn
☐ Hepatic (Liver) Disorder
☐ Hepatitis
☐ HIV Infection
☐ High Cholesterol
☐ High Blood Pressure
☐ Inherited Skin Disease
☐ Irritable Bowel Syndrome
☐ Keloids
☐ Kidney Disease
☐ Lower Back Pain
☐ Valve Disorder
☐ Multiple Sclerosis
☐ Murmurs
☐ Neurologic Disease
☐ Obesity
☐ Osteoporosis
☐ Peripheral Vascular Disease (Poor Circulation)
☐ Pulmonary Disease (Lung Disease)
☐ Recent Methicillin-resistant Staph aureus (MRSA)
☐ Seizure Disorder
☐ Skin Cancer
☐ Skin Cancer - BCC
☐ Skin Cancer - SCC
☐ Skin Cancer - MM
☐ Stroke Syndrome
☐ Thromboembolic Disease (Blood Clot Disorder)
☐ Thyroid Disorder
☐ 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*
☐ Acne		☐ High Blood Pressure	
☐ Autoimmune Disorder (i.e. Lupus)		☐ High Cholesterol	
☐ Anemia (Low Blood Count)		☐ Kidney Disease	
☐ Cancer - list type(s):		☐ Lung Disease	
		☐ Psoriasis	
		☐ Skin Cancer	
☐ Diabetes Mellitus		☐ Stroke Syndrome	
☐ Eczema		☐ Tension	
☐ 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: _____

☐ **No History of 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

Review of systems: ☐ No Known Symptoms ☐ All Others Negative

Do you have the following symptoms now? *(check all that apply)*:

Fever	☐ Y ☐ N	Chest Pain	☐ Y ☐ N	Dizziness/Headache	☐ Y ☐ N	Anxiety	☐ Y ☐ N
Recent Weight Loss	☐ Y ☐ N	Shortness of Breath	☐ Y ☐ N	Weakness	☐ Y ☐ N	Diarrhea	☐ Y ☐ N
Feeling Tired	☐ Y ☐ N	Cough	☐ Y ☐ N	Difficulty Walking	☐ Y ☐ N	Irregular Menses	☐ Y ☐ N
Eyesight Problems	☐ Y ☐ N	Abdominal Pain	☐ Y ☐ N	Easy Bruising	☐ Y ☐ N	Sun Sensitivity	☐ Y ☐ N
Loss of Hearing	☐ Y ☐ N	Pain on Urination	☐ Y ☐ N	Seasonal Allergies	☐ Y ☐ N	Dry Eyes/Mouth	☐ Y ☐ N
Mouth Ulcers	☐ Y ☐ N	Joint Pain	☐ Y ☐ N	Headaches	☐ Y ☐ N		

Allergies: ☐ No Known Allergies

Allergy	Reaction	Allergy	Reaction

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

Medications/Blood Thinners	Dosage	Frequency	Medications/Blood Thinners	Dosage	Frequency

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

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:** _____

Jefferson University Physicians

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 University Physicians

Patient Demographics Form

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

Jefferson University Physicians ("JUP") is participating in the Medicare and Medicaid Electronic Health Record Incentive Program ("Program"). The federal government requires us to record specific demographic information about all of our patients. We are asking you to provide the demographic information below for Program purposes. Please check the appropriate boxes below. **Only one entry in each section can be chosen.**

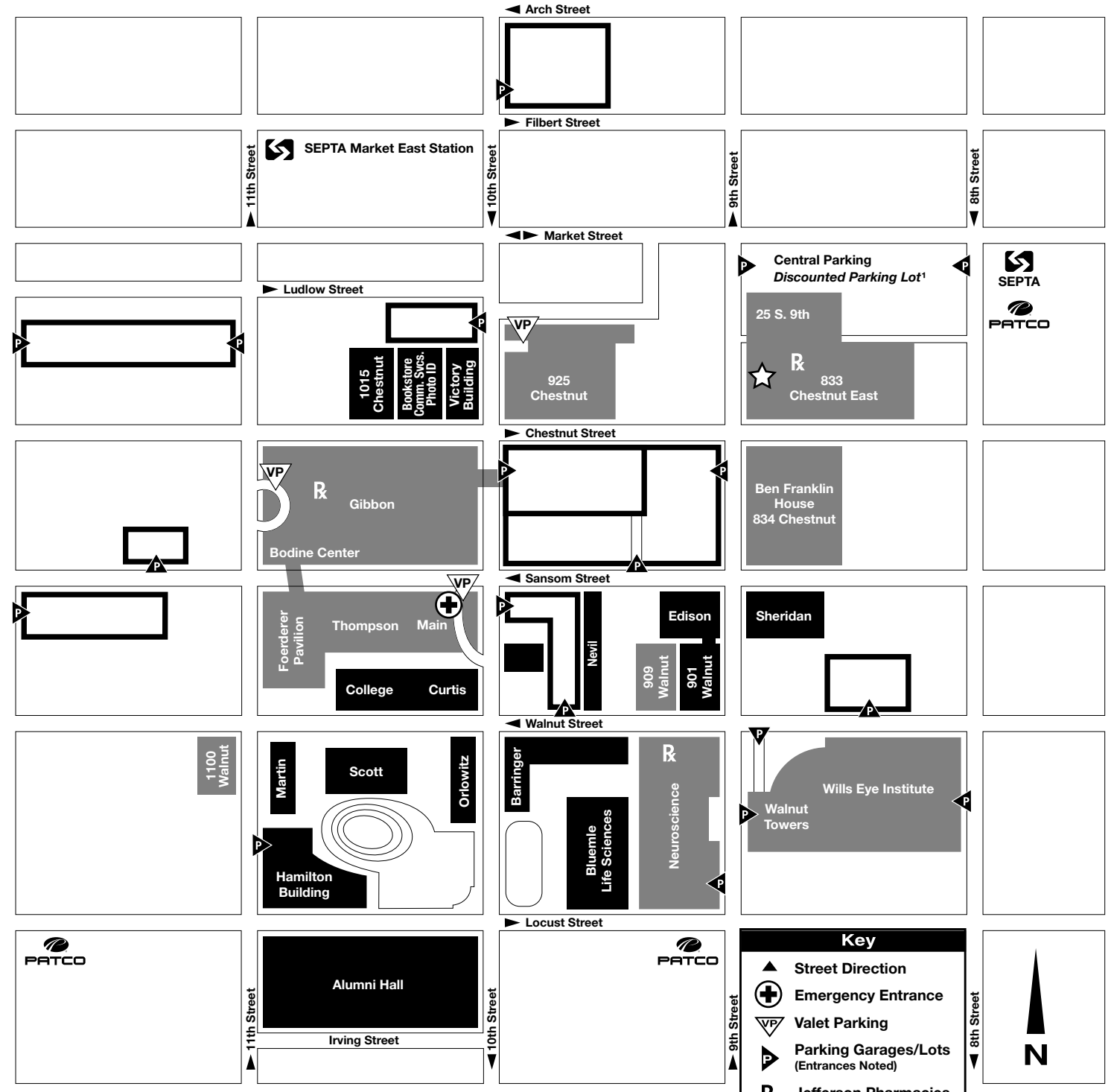
1. **Language:**
   - ☐ English
   - ☐ Other (Please List) _____

2. **Race:**
   - ☐ African American or Black
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Caucasian or White
   - ☐ Native Hawaiian or Other Pacific Islander
   - ☐ Unknown
   - ☐ Declined

3. **Ethnicity:**
   - ☐ Hispanic or Latino
   - ☐ Non-Hispanic or Non-Latino
   - ☐ Unknown
   - ☐ Declined

Jefferson
University Physicians

Campus Map
Center City



[1] Jefferson Dermatology ONLY offers discounted parking for 'Central Parking' located between 8th and 9th streets on Market.

87947 (REV. 05/13) JG 13-1942

Getting to Center City Campus

The Jefferson campus is bound by 8th and 11th Streets and Chestnut and Locust Streets. These directions will take you to the center of campus. Please refer to the campus map for specific building locations.

By Car

From the Betsy Ross Bridge and Points Northeast of Philadelphia

- Follow I-95 south to Exit 22 (Central Philadelphia)
- At the end of the ramp, turn right onto Callowhill Street
- Continue on Callowhill Street to 8th Street
- Turn left onto 8th Street and continue to the Jefferson campus

From Points North and West of Philadelphia

- Take Exit 326 (old exit 24) (Valley Forge) from Pennsylvania Turnpike
- Take Rt. 76 East and follow signs for Exit 344 (Central Phila/676 East)
- Take Exit 344 to Vine Street and follow Vine Street to 8th Street
- Turn right onto 8th Street and continue to the Jefferson campus

From Route 309

- Take Route 309 South to the end of the expressway
- Turn right onto Rt. 611 South (Broad Street)
- Continue on Broad Street (approximately six miles) to Vine Street
- Turn left onto Vine Street and follow to 8th Street
- Turn right onto 8th Street and continue to the Jefferson campus

From the Philadelphia Airport

- Take Rt. I-95 North to Exit 22 (Central Philadelphia)
- From the exit, stay in the left lanes and follow signs to Callowhill Street
- Once on Callowhill Street, stay in the middle lane and continue to 8th Street
- Turn left onto 8th Street and continue to the Jefferson campus

From Delaware and Points South of Philadelphia

- Take Rt. I-95 North to Exit 22 (Central Philadelphia)
- From the exit, stay in the left lanes and follow signs to Callowhill Street
- Once on Callowhill Street, stay in the middle lane and continue to 8th Street
- Turn left onto 8th Street and continue to the Jefferson campus

From the Main Line

- Take Rt. 476 North to 76 East and follow signs for Exit 344 (Central Phila/676 East)
- Take Exit 344 to Vine Street and follow Vine Street to 8th Street
- Turn right onto 8th Street and continue to the Jefferson campus

From New Jersey via the Walt Whitman Bridge

- Cross the Walt Whitman Bridge. After the toll booth, take I-95 North to Exit 22 (Central Philadelphia)
- From the exit, stay in the left lanes and follow signs to Callowhill Street
- Once on Callowhill Street, stay in the middle lanes and continue to 8th Street
- Turn left onto 8th Street and continue to the Jefferson campus

From New Jersey via the Ben Franklin Bridge

- Cross the Ben Franklin Bridge. After the toll booth, stay in the middle lane directing you to 8th Street
- Turn left onto 8th Street
- Follow 8th Street to Jefferson Campus.

From the New Jersey Turnpike

- Take Exit 4 (Rt. 73 North) from the New Jersey Turnpike
- Follow Rt. 73 North to Rt. 38 West
- Continue on Rt. 38 West (follow signs for the Ben Franklin Bridge) to the Admiral Wilson Boulevard and the bridge
- Cross the Ben Franklin Bridge and follow directions immediately above

By Public Transit

From Northeast Philadelphia

- Take the westbound Market-Frankford elevated to 8th and Market Streets
- Walk west on Market to 9th Street, then south on 9th Street one block to the Jefferson campus at 9th and Chestnut Streets

From South Philadelphia

- Take the Broad Street subway to City Hall and transfer (free) to the eastbound Market-Frankford elevated
- Take the eastbound Market-Frankford elevated to 8th and Market Streets
- Walk west on Market to 9th Street, then south on 9th Street one block to the Jefferson campus at 9th and Chestnut Streets

From West Philadelphia

- Take the eastbound Market-Frankford elevated to 8th and Market Streets
- Walk west on Market to 9th Street, then south on 9th Street one block to the Jefferson campus at 9th and Chestnut Streets

From the Philadelphia Airport

- Take R1 from the airport to Center City. Please check with SEPTA for the latest fares
- Call SEPTA at (215) 580-7800 for schedule
- Take the train to the Market East Station at 8th and Market Streets
- Walk west on Market to 9th Street, then south on 9th Street one block to the Jefferson campus at 9th and Chestnut Streets

From the Suburbs

- Call SEPTA at (215) 580-7800 to determine the regional rail line closest to your home
- Take the train to the Market East Station at 8th and Market Streets
- Walk west on Market to 9th Street, then south on 9th Street one block to the Jefferson campus at 9th and Chestnut Streets

From New Jersey

- Take the PATCO High Speed Line to the 8th and Market Station
- Walk west on Market to 9th Street, then south on 9th Street one block to the Jefferson campus at 9th and Chestnut Streets

87947 (REV. 05/13) JG 13-1942