Jefferson®
at the Navy Yard

Jefferson University Physicians

T 215.503.3300 F 215.503.3321

Allergy
Audiology
Family Medicine
Medical Oncology
Otolaryngology
Pain Management
Urology

Thank for you for selecting Jefferson at the Navy Yard for your care.

We ask that you arrive15 minutes prior to your scheduled visit. Should you need to cancel or re-schedule your visit for any reason, we require that you contact 1-800 JEFF NOW (1-800-533-3669) within 48 hours prior to your scheduled visit.

Also, if you arrive for your appointment 15 minutes beyond the scheduled time, you may be asked to reschedule your 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 applicable)
- Request for consultation by your referring physician (if applicable)
- Photo ID - this is a requirement of federal regulations
- Payment for services - cash, check or credit card. Please note that co-payments are contractually required and must be paid at the time of the visit.

In addition, it may be necessary for you to bring medical information with you. The following items need to be brought with you to the office on the day of your visit if applicable:

- Medical records including information associated with a recent hospitalization, for example: Discharge Summary or Operative Note
- Diagnostic Studies (MRI, CAT Scan, Ultrasounds) - including the films and written reports.
- Pathology or Lab Studies - results of recent lab work or pathology slides and reports.
- A list of all medication - prescribed, over the counter and herbal supplements.

Enclosed are several documents that you will need to complete in advance of your visit. By doing so, you will ensure that your scheduled appointment time with your provider is not further delayed.

For additional information you can visit our website:
www.jeffersonhospital.org/navyyard

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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

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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: ______________

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: ______________

Jefferson at the Navy Yard

TW MRN # ______

Medical History Questionnaire

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

Patient's Name: ______ Date of Birth: ______

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

Surgery: ☐ No Surgical History

Surgery	Date

Family History: ☐ No Family Medical History

(check all that apply)	Family Member*	(check all that apply)	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.

Medical History Questionnaire

Patient Name ____ DOB ____ TW MRN# ____

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 ☐ Cigars ☐ Chewing Tobacco ☐ Pipe Packs/Times Per Day: ____ Years ____
☐ 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

Do you have the following symptoms now? ☐ No Known Symptoms

Fever	☐ Yes ☐ No	Sore Throat	☐ Yes ☐ No	Pain on Urination	☐ Yes ☐ No	Difficulty Walking	☐ Yes ☐ No
Recent Wt Loss	☐ Yes ☐ No	Hoarseness	☐ Yes ☐ No	Joint Pain	☐ Yes ☐ No	Muscle Weakness	☐ Yes ☐ No
Feeling Tired	☐ Yes ☐ No	Chest Pain	☐ Yes ☐ No	Limb Pain	☐ Yes ☐ No	Easy Bruising	☐ Yes ☐ No
Eyesight Problems	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No	Skin Lesions	☐ Yes ☐ No	Seasonal Allergies	☐ Yes ☐ No
Loss of Hearing	☐ Yes ☐ No	Cough	☐ Yes ☐ No	Dizziness	☐ Yes ☐ No		
Nasal Discharge	☐ Yes ☐ No	Abdominal Pain	☐ Yes ☐ No	Limb Weakness	☐ Yes ☐ No		

Allergies:

☐ No Known Allergies

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:** ____

Jefferson.
University Physicians

Acct:

Allergy Questionnaire

Name: (Please Print) ______________________ DOB: __________

1. Please describe, in your own words, the reason you are here today to see an ENT allergist:

____

____

2. Have you ever been allergy tested? ☐ Yes ☐ No; If yes, when/where? ______________

3. Have you ever had a severe allergic reaction? ☐ Yes ☐ No; If yes, describe ______________

4. Do you have asthma? ☐ Yes ☐ No; If yes, which medications do you use for asthma control?

____

5. Do you cough, have trouble breathing, or chest tightness when exercising? . . . . ☐ Yes ☐ No

6. Do you hear wheezing noises inside your chest? . . . . ☐ Yes ☐ No

7. Do you cough or have trouble breathing when it's very hot or cold outside? . . . . ☐ Yes ☐ No

8. Do you cough or have trouble breathing when around pets, dust, smoke, or pollen? . . . . ☐ Yes ☐ No

9. Do you wake up at night because of breathing problems or coughing? . . . . ☐ Yes ☐ No

10. Please check below the symptoms you are troubled with:

Eyes:	☐ burning	☐ itching	☐ watery	☐ puffy	☐ dark circles
Nose:	☐ stuffy nose	☐ runny nose	☐ itchy nose	☐ sneezing	☐ decreased sense of smell
Throat:	☐ post-nasal drip	☐ sore throat	☐ hoarse voice		
Ears:	☐ popping	☐ fullness in ears	☐ fluid in ears	☐ ear pain	☐ ear infections

11. How long have you had allergy symptoms? ______________

12. Which medicines have you used for your allergy symptoms? ______________

____

13. Which medicines have actually **helped** relieve your allergy symptoms? ______________

____

14. Do you get frequent sinus infections? ☐ Yes ☐ No; How many per year? ______________

Patient Initials ________

Please continue on next page.

Jefferson at the Navy Yard
3 Cresecent Drive, Suite 100, Philadelphia, PA 19112 • **215-503-3300** • **Fax: 215-503-3321**

FORM 85467 (REV. 04/12) JG 12-1938

Acct:

Name: (Please Print) ______________________ DOB: ______________

15. Are your symptoms getting worse over time? ☐ Yes ☐ No

16. Which of the following statements best describes the frequency of your symptoms (please check one):
    - ☐ My symptoms are present all year long
    - ☐ My symptoms come and go throughout the year without a particular pattern
    - ☐ My symptoms occur seasonally; Please circle the months when your symptoms occur:

    Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

17. Is there a time of day when your symptoms are worse? ☐ Yes ☐ No; If yes, please indicate below:

    ☐ Morning ☐ Afternoon ☐ Evening

18. Do your symptoms disturb your sleep?. . . . . ☐ Frequently ☐ Occasionally ☐ Never

19. Do you miss work because of your symptoms? . . . . ☐ Frequently ☐ Occasionally ☐ Never

20. Surroundings (Please indicate below where and when your symptoms occur):

Outdoors	**Indoors**
☐ after mowing lawn	☐ in basement/crawl space
☐ while exercising	☐ after dusting/vacuuming
☐ in damp areas	☐ in bedroom
☐ near farms/barns	☐ around pets
☐ on windy days	

21. Do you have carpets in your home? If yes, which rooms are they in? ______________

22. Do you have pets in your home? If yes, please indicate: ☐ Cat ☐ Dog Other: ______________

23. Do you smoke? ☐ Yes ☐ No; Does anyone in your house smoke? ☐ Yes ☐ No

24. Do you have any food allergies? ☐ Yes ☐ No; If yes, describe: ______________

25. Do you have a history of eczema?. . . . . ☐ Yes ☐ No

26. Is there a family history of allergies? . . . . ☐ Yes ☐ No

Patient Signature: ______________________ Date: ______________

Physician Signature: ______________________ Date: ______________

☐ Fisher ☐ Artz

Patient Initials ________

From Center City

By Car

Take Broad Street south to the Navy Yard. Enter the Navy Yard and turn left at first light onto Crescent Drive.

By SEPTA

Take the Broad Street Subway (Orange Line) south to Pattison Avenue.

Take Bus #71 on the Southeast corner of Broad Street to the Navy Yard.

Exit at Crescent Drive.

From New Jersey via Walt Whitman Bridge

Cross the Walt Whitman Bridge.

After the toll booth, take Exit 349 (Broad Street/Sports Complex).

Turn left at the first light onto Broad Street.

Follow Broad Street approximately one mile to the Navy Yard.

Enter the Navy Yard and turn left at the first light onto Crescent Drive.

From Delaware and Points South of Philadelphia

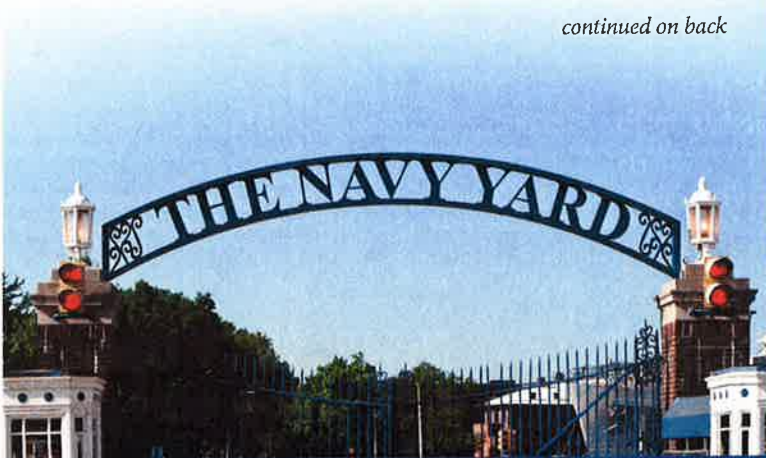
Take I-95 North to Exit 17 (Broad Street/Pattison Avenue).

Turn left at first light (Zinkoff Boulevard) and make immediate left onto Broad Street.

Get in right lane (avoid the entrance to I-95) and follow Broad Street into the Navy Yard.

Enter the Navy Yard and turn left at the first light onto Crescent Drive.

continued on back



From Points North

Take I-95 South to Exit 17 (Broad Street/Pattison Avenue).

Stay to the left.

Cross over Broad Street and then make a left onto Broad Street at the second light.

Enter the Navy Yard and turn left at the first light onto Crescent Drive.

From the Western Suburbs

Take 476 South to I-95 North.

Take I-95 North to Exit 17 (Broad Street/Pattison Avenue).

Turn left at the first light (Zinkoff Boulevard) and make an immediate left onto Broad Street.

Get in right lane (avoid the entrance to I-95) and follow Broad Street into the Navy Yard.

Enter the Navy Yard and turn left at the first light onto Crescent Drive.

Parking

Free parking is available. The parking lot is located behind 3 Crescent Drive: Turn right at the stop sign and make the next right into the parking lot.

For more information about Jefferson at the Navy Yard, call **1-800-JEFF-NOW** or visit us online at **www.JeffersonHospital.org/navyyard**