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

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

# 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** | **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<br>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
at the Navy Yard

## 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*


THOMAS JEFFERSON UNIVERSITY AND HOSPITALS

## 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**