

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 arrive 15 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](http://www.jeffersonhospital.org/navyyard)

<b>Today's Date:</b>
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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 <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number - -	Language <input type="checkbox"/> English <input type="checkbox"/> Other _____	
Race <input type="checkbox"/> African American or Black <input type="checkbox"/> American Indian or Alaska Native		<input type="checkbox"/> Asian <input type="checkbox"/> Caucasian or White	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Declined	
Ethnicity <input type="checkbox"/> Hispanic or Latino		<input type="checkbox"/> Non-Hispanic or Non-Latino	<input type="checkbox"/> Unknown <input type="checkbox"/> Declined	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Other _____				
Address Line 1		Address Line 2		
City			State	Zip
Home Phone		Daytime Phone	Cell Phone	
Home E-mail				
Emp Status <input type="checkbox"/> Employed Full Time <input type="checkbox"/> Employed Part Time <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Active Military <input type="checkbox"/> Disabled <input type="checkbox"/> Homemaker <input type="checkbox"/> Student <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> 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**

<input type="checkbox"/> Billboard	<input type="checkbox"/> Brochure	<input type="checkbox"/> Health Fair	<input type="checkbox"/> Health Plan	<input type="checkbox"/> Internet	<input type="checkbox"/> JEFF NOW®	<input type="checkbox"/> Mass Mailing	<input type="checkbox"/> Newspaper/Mag.	<input type="checkbox"/> Ongoing Care
<input type="checkbox"/> Patient	<input type="checkbox"/> Phone Book	<input type="checkbox"/> Phys. Off./ER	<input type="checkbox"/> Relative	<input type="checkbox"/> Radio	<input type="checkbox"/> TV	<input type="checkbox"/> Word of Mouth	<input type="checkbox"/> 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	

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: \_\_\_\_\_



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: \_\_\_\_\_



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: \_\_\_\_\_

<b>Past Medical History</b> (check all that apply):		<input type="checkbox"/> <b>No Past Medical History</b>
<input type="checkbox"/> Acute Myocardial Infarction (Heart Attack)	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Anemia (Low Blood Count)	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Pulmonary Disease (Lung Disease)
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hepatic (Liver) Disorder	<input type="checkbox"/> Recent Methicillin-resistant Staph aureus (MRSA)
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Autoimmune Disorder (Lupus/Scleroderma/RA)	<input type="checkbox"/> HIV Infection	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Blood Transfusion Complications	<input type="checkbox"/> Hypercholesterolemia	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Cancer - list type(s):	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Stroke Syndrome
	<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Thromboembolic Disease (Blood Clot Disorder)
	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Thrombophlebitis
	<input type="checkbox"/> Lower Back Pain	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Chest Pain (Angina)	<input type="checkbox"/> Mitral Valve Disorder	<input type="checkbox"/> Transient Ischemic Attack (Mini Stroke)
<input type="checkbox"/> Chronic Liver Disease	<input type="checkbox"/> Murmurs	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> COPD (Chronic Obstructive Pulmonary Disease)	<input type="checkbox"/> Obesity	<input type="checkbox"/> Other (specify):
<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Obstructive Sleep Apnea	
<input type="checkbox"/> Emotional Disturbance	<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Gastric/Duodenal Ulcer	<input type="checkbox"/> Peripheral Vascular Disease (Poor Circulation)	

<b>Surgery:</b>	<input type="checkbox"/> <b>No Surgical History</b>	<b>Date</b>

<b>Family History:</b>		<input type="checkbox"/> <b>No Family Medical History</b>	
(check all that apply)	Family Member*	(check all that apply)	Family Member*
<input type="checkbox"/> Anemia (Low Blood Count)		<input type="checkbox"/> Hypercholesterolemia	
<input type="checkbox"/> Cancer - list type(s):		<input type="checkbox"/> Hypertension	
		<input type="checkbox"/> Osteoporosis	
		<input type="checkbox"/> Pulmonary Disease	
<input type="checkbox"/> COPD		<input type="checkbox"/> Renal Disease	
<input type="checkbox"/> Diabetes Mellitus		<input type="checkbox"/> Stroke Syndrome	
<input type="checkbox"/> Emphysema		<input type="checkbox"/> Thromboembolic Disease	
<input type="checkbox"/> Heart Disease		<input type="checkbox"/> Unattainable-Patient Adopted	
<input type="checkbox"/> Hepatic (Liver) Disorder		<input type="checkbox"/> 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# \_\_\_\_\_

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## Social History:

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

(check all that apply):

<input type="checkbox"/> Alcohol Use	Weekly: _____
<input type="checkbox"/> Drug Use (Recreational)	Explain: _____
<input type="checkbox"/> Using Intravenous Drugs	Explain: _____
<input type="checkbox"/> Previous History of Smoking	
Date Quit: _____ Packs Per Day _____ Years of Smoking: _____	
Attempts to Quit: _____ Methods Used to Quit: _____	
<input type="checkbox"/> No History of Smoking	
<input type="checkbox"/> Wishing to Stop Smoking	
<input type="checkbox"/> Smoking/Nicotine Substances	<input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipe Packs/Times Per Day: _____ Years _____
<input type="checkbox"/> Current Diet	Explain: _____
<input type="checkbox"/> Exercise Habits	Times per week: _____
<input type="checkbox"/> Being Sedentary (Do not exercise)	
<input type="checkbox"/> Sexually Active	
<input type="checkbox"/> Occupation	List All: _____
<input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain on Urination	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Walking	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recent Wt Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hoarseness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Feeling Tired	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Limb Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easy Bruising	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eyesight Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seasonal Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Nasal Discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abdominal Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Limb Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> 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: \_\_\_\_\_



### 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

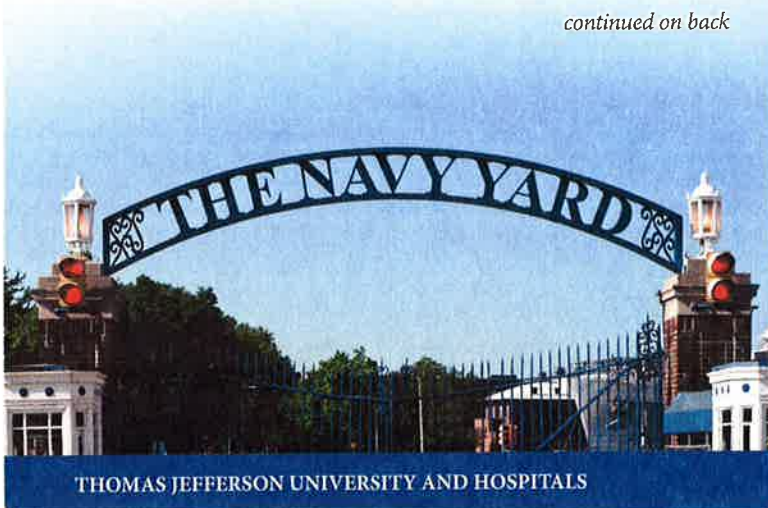
Take I-95 North to Exit 17 (Broad Street/Pattison Avenue).

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](http://www.JeffersonHospital.org/navyyard)

