Jefferson

Department of Otolaryngology - Head and Neck Surgery

Dear Patient,

Thank you for selecting Jefferson University Physician's Department of Otolaryngology - Head and Neck Surgery for your care.

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 that you contact our office 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 - A copy of your photo ID will be kept on file for your protection and as a requirement of federal identity protection guidelines.
- Payment for services - cash, check, or credit card. Please note that co-payments are contractually required and must be paid at time of the visit.

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. In addition, we have enclosed a map of the Jefferson Campus which will help guide you to our office. This map provides details for nearby parking facilities but please note that patients are responsible to pay for their own parking. You may also visit our website: Jefferson.edu/JUP.

We thank you for choosing Jefferson University Physicians to provide your care.

Sincerely,

Department of Otolaryngology - Head and Neck Surgery

Jefferson

Department of Otolaryngology - Head and Neck Surgery

You Have Scheduled an Appointment with Our Physicians

Thank you for scheduling your appointment with the Department of Otolaryngology.

To better serve you, we ask that you please bring all of your records from your previous care provider to your scheduled appointment.

Please bring a copy of the following records upon your arrival:

- Written imaging reports of CT, MRI, PET scan and Ultrasound
- CD/DVD of CT, MRI, PET Scan and Ultrasound
- Operative Reports
- Pathology Reports
- Any notes from your previous physicians that will aid in your treatment plan
- Any other pertinent medical information

If you have any questions or concerns, please contact the office at 215-955-6760.

Thank you for your cooperation. We look forward to providing you with comprehensive care.

Jefferson

TW MRN # _____

Department of Otolaryngology – Head & Neck Surgery

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.

IMPORTANT: DO NOT WRITE IN MARGINS

Department of Otolaryngology – Head and Neck Surgery
925 Chestnut Street, Sixth Floor, Philadelphia, PA 19107 • **215-955-6760**

Department of Otolaryngology - Head and Neck Surgery

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:** _____

☐ M.Boon, MD ☐ S.Brady, NP ☐ J.Carey, NP ☐ D.Cognetti, MD ☐ J.Curry, MD ☐ T.DiFabio, NP ☐ K.Fisher, MD ☐ R.Heffelfinger, MD ☐ W.Keane, MD
☐ H.Krein, MD ☐ A.Luginbuhl, MD ☐ B.McGettigan, MD ☐ G.Nyquist, MD ☐ S. Pelosi, MD ☐ E.Pribitkin, MD ☐ D.Rosen, MD ☐ M.Rosen, MD ☐ J.Spiegel, MD ☐ T.Willcox, MD

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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 ☐ Not-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		Preferred Phone	Cell Phone	
Home E-mail				
Emp Status ☐ Employed Full Time ☐ Employed Part Time ☐ Self-Employed ☐ Unemployed ☐ Disabled ☐ Active Military ☐ Homemaker ☐ Student Full Time ☐ Student Part Time ☐ 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	Guarantor's Home Phone
Guarantor's Address Line 1		Guarantor's Address Line 2		Guarantor's Work Phone
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	Primary Phone	Secondary 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

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: _____

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™

TW #_____

DOB:_____

To Our Valued Patients:

From time to time we like to announce new and exciting product lines, specials and open houses. We plan to announce these events using email. If you would be interested in receiving these announcements, please enter your email address below and sign the bottom of this form.

Thank you so much for your interest and participation,

Department of Otolaryngology-Head and Neck Surgery Staff

_____

E-mail address

_____

Signature

_____

Printed Name

I am interested in (select all that apply):

- ☐ General information from Otolaryngology-Head and Neck Surgery
- ☐ Hearing Aids
- ☐ Facial Plastic and Reconstructive Surgery information
- ☐ Voice and Swallowing information
- ☐ Thyroid Surgery information
- ☐ Snoring and Sleep Apnea information
- ☐ Allergy Services
- ☐ Jefferson Otolaryngology Wellness Program

If you would like to stop receiving emails regarding our products and promotions, please contact:
Danielle DeMaio-DeAngelis at danielle.demaio-deangelis@jefferson.edu
925 Chestnut Street, 6th Floor, Philadelphia, PA 19107, 215-955-6784.

Jefferson™

Authorization To Use And Disclose Patient Photographs And Video Diary For Educational And Marketing Purposes

I, _____ [Patient Name] am a patient of Jefferson University Physicians' Department of Otolaryngology ("Jefferson"). As part of my medical and health care treatment, I authorized Jefferson to take photographs, slides and/or videotapes (collectively, "photographs") of parts of my body including before and after surgery photographs of my face. I understand that these photographs have become part of my medical record and are confidential health information. In addition, I understand Jefferson would like to send me home with a "flip camera" or similar device to allow me to record a video diary of my progress ("video diary"). I understand that this video diary will not become part of my Jefferson medical record.

1. **Authorization to Use Photographs and Video Diary for Educational and Marketing Purposes.** I understand that Jefferson wants to be able to use my photographs and my video diary for purposes other than to provide medical and health care treatment to me. I understand that for marketing purposes, Jefferson wants to disclose my photographs and video diary, without identifying me by name, to individuals seeking similar medical treatment at Jefferson. For marketing purposes, Jefferson may place my photographs or video diary in a Jefferson photo album for prospective patients to see. Jefferson may also use my photographs or video diary in a print advertisement or on its website, both of which will be available to the public. I also understand that for educational purposes, Jefferson wants to disclose my photographs and video diary, without identifying me by name, to attendees at various medical conventions or seminars when Jefferson is participating as a presenter. Attendees may include healthcare professionals and others. For educational purposes, Jefferson also wants to publish my photographs and video diary in medical journals and textbooks, and when teaching courses to educate the health care profession and the general public about plastic surgery. I understand that, although Jefferson will not disclose my name when using my photographs or video diary for marketing or educational purposes, *someone may be able to identify me from the photographs or video diary*.

2. **Compensation.** I understand that I will not receive any money for permitting Jefferson to use my photographs or video diary for the purposes described in this authorization. I understand that Jefferson may receive payment for some of the activities in which my photographs or video diary may be used.

3. **Expiration Date/Right to Revoke.** I understand that this authorization will not expire. I understand that I have the right to revoke this authorization in writing to the Administrator of Jefferson and may do so any time. If Jefferson has already used or disclosed my photographs or video diary before receiving my revocation, I understand that Jefferson cannot take back those uses or disclosures.

4. **Information May Be Re-disclosed.** I understand that my photographs and video diary may be subject to re-disclosure by a recipient of the photographs or video diary.

5. **No Condition on Authorization.** I understand that there will be no consequences to me if I choose not to sign this form.

6. **Authorization and Signature.** I understand how Jefferson plans to use and disclose my photographs and video diary. By signing below, I authorize Jefferson to use and disclose my photographs for the purposes described in this authorization. By signing below and giving to Jefferson the video diary that I have taken of myself, I authorize Jefferson to use and disclose my video diary for the purposes described in this authorization. By signing this form, I certify that Jefferson has answered all of my questions to my satisfaction and I knowingly, willingly and voluntarily authorize Jefferson to use my photographs and video diary for the stated purposes.

Signature of Patient: _____ **Date:** _____

Staff Use Only		
Patient	DOB	MRN#

Department of Otolaryngology - Head and Neck Surgery
925 Chestnut Street, 6th Floor, Philadelphia, PA 19107 • **215-955-6760**

Jefferson™

Consent For Electronic Mail ("Email") Use

Jefferson University Physicians ("JUP") offers its patients the opportunity to communicate by Email for non-urgent matters. This form provides the guidelines and documents your consent for Email use.

Email	Use of Email communications should be between JUP and an adult patient 18 years of age or older, or the parent or guardian of a minor.
Do Not Use Email	**DO NOT USE EMAIL IN CASE OF A MEDICAL EMERGENCY OR URGENT OR TIME SENSITIVE MATTERS.** Do not use Email for communicating sensitive health care information such as sexually transmitted diseases, HIV, hepatitis, substance abuse, mental health or presence of malignancy. Do not send any attachments by Email. Do not use Email to request copies of medical records. Do not use an employer's computer to send Emails. Employers have a right to archive and inspect Emails transmitted through their systems. Do not use Email as a substitute for clinical evaluations and office appointments.
Privacy, Security & Confidentiality	Although JUP has implemented reasonable technical safeguards, JUP cannot and does not guarantee the privacy, security or confidentiality of any Email messages sent or received over the Internet. There is a potential that Email sent or received over the Internet can be intercepted, altered, forwarded, and/or read by others. JUP is not responsible for Email messages that are lost due to technical failure during composition, transmission, or storage. JUP will not forward Emails to independent third parties without a patient's prior written consent, except as authorized or required by law. Patients must inform JUP of Email address changes. Patients should take precautions to preserve the confidentiality of Email, such as safeguarding computer passwords.
Creating a Message	In the "Subject" line of the Email, patients should include the general topic of their message (i.e., medical advice). In the "Body" of the Email message, include the patient's name and date of birth. This information is necessary to verify your identity and make sure JUP can include the Email in the correct medical record.
Email Message	Email communications should only be used for non-sensitive and non-urgent issues, such as general medical advice after an initial face-to-face visit
Email Response	JUP cannot guarantee that you will receive a response to any particular Email. If you have not received a response within a reasonable time period, please call your JUP provider.
Documentation	All Emails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those Emails.
Email Use by JUP	You understand that if you give your Email address to JUP and sign this consent form, you are allowing JUP to use Email to communicate with you. JUP includes all of its departments, practice sites and providers.
Ending Email	You may stop communicating by Email by sending an Email or letter to JUP.

ACKNOWLEDGEMENT: I acknowledge that I have read and fully understand this consent form and that I voluntarily request the use of Email as one form of communication with JUP.

_____ **X** _____

Patient Printed Name | Patient Signature

_____ _____

Patient Email Address | Date

Jefferson
HEALTH IS ALL WE DO

3300 Tillman Drive
1st Floor Rothman Building at Rear of Complex
Bensalem, PA 19020

215-244-2430

Jefferson at Holy Redeemer-Bensalem

We are inside the Rothman Surgery Center Building on the 1st floor at the rear of the complex. Go through the glass doors and the greeters will direct you.

From Points South

1. Take I-95 North to the Street Road Exit/PA 132.
2. Exit at the Street Road and turn left onto Street Road/PA 132 W. Follow Street Road for approximately 3 miles.
3. Turn left onto Tillman Drive (across from the Philadelphia Park Racetrack). End at 3300 Tillman Drive. Our office is inside the Rothman Surgery Center Building on the 1st floor at the rear of the complex. Go through the glass doors and the greeters will direct you.

From Points East/West

1. Take Route. 1 South (exit to the right after tolls) to the Street Road/Route 132 East/Philadelphia Park exit.
2. Turn right onto Tillman Drive (across from the Philadelphia Park Racetrack). End at 3300 Tillman Drive. Our office is inside the Rothman Surgery Center Building on the 1st floor. Go through the glass doors and the greeters will direct you.

From Points North

1. Take I-95 South to Exit #46B toward Langhorne/ Route 1 South. Follow Route 1 South for approximately 3 miles.
2. Exit at the Street Road Exit/PA 132 E. Follow Street Road for less than 1 mile.
3. Turn right onto Tillman Drive (across from the Philadelphia Park Racetrack). End at 3300 Tillman Drive. Our office is inside the Rothman Surgery Center Building on the 1st floor. Go through the glass doors and the greeters will direct you.

CC 22409 (REV. 10/14)