



## 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](http://Jefferson.edu/JUP).

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

Sincerely,

Department of Otolaryngology - Head and Neck Surgery



## Department of Otolaryngology - Head and Neck Surgery

### You Have Scheduled an Appointment with Our Physicians

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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.



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):		<input type="checkbox"/> No Past Medical History
<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"/> Lower Back Pain	
<input type="checkbox"/> Chest Pain (Angina)	<input type="checkbox"/> Mitral Valve Disorder	<input type="checkbox"/> Thrombophlebitis
<input type="checkbox"/> Chronic Liver Disease	<input type="checkbox"/> Murmurs	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> COPD (Chronic Obstructive Pulmonary Disease)	<input type="checkbox"/> Obesity	<input type="checkbox"/> Transient Ischemic Attack (Mini Stroke)
<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Obstructive Sleep Apnea	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Emotional Disturbance	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Other (specify):
<input type="checkbox"/> Gastric/Duodenal Ulcer	<input type="checkbox"/> Peripheral Vascular Disease (Poor Circulation)	

IMPORTANT: DO NOT WRITE IN MARGINS

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

Family History:		<input type="checkbox"/> No Family Medical History	
(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# \_\_\_\_\_

**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	<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: \_\_\_\_\_

- 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

<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"/> Not-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		Preferred 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"/> Disabled <input type="checkbox"/> Active Military <input type="checkbox"/> Homemaker <input type="checkbox"/> Student Full Time <input type="checkbox"/> Student Part Time <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	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**

<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: \_\_\_\_\_



# 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:** \_\_\_\_\_



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](mailto:danielle.demaio-deangelis@jefferson.edu)  
925 Chestnut Street, 6th Floor, Philadelphia, PA 19107, 215-955-6784.





## 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#



## 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.

<b>Email</b>	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.
<b>Do Not Use Email</b>	<b>DO NOT USE EMAIL IN CASE OF A MEDICAL EMERGENCY OR URGENT OR TIME SENSITIVE MATTERS.</b> 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.
<b>Privacy, Security &amp; Confidentiality</b>	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.
<b>Creating a Message</b>	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.
<b>Email Message</b>	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
<b>Email Response</b>	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.
<b>Documentation</b>	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.
<b>Email Use by JUP</b>	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.
<b>Ending Email</b>	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.

\_\_\_\_\_  
Patient Printed Name

**X** \_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient Email Address

\_\_\_\_\_  
Date

## Jefferson at the Navy Yard

The entrance to Jefferson at the Navy Yard is located at the back of the building. We are on the first floor of 3 Crescent Drive, in Suite 100.

### ■ From Center City

1. Take Broad Street South to the Navy Yard.
2. Enter the Navy Yard and turn left at first light onto Crescent Drive.
3. Make a right at the stop sign. Jefferson at the Navy Yard is in the building to your left.

### ■ From Delaware and Points South of Philadelphia

1. Take 1-95 North to Exit 17 (Broad Street/Pattison Avenue).
2. Turn left at first light (Zinkoff Boulevard) and make immediate left onto Broad Street.
3. Get in right lane (avoid the entrance to 1-95) and follow Broad Street into the Navy Yard.
4. Enter the Navy Yard and turn left at the first light onto Crescent Drive.
5. Make a right at the stop sign. Jefferson at the Navy Yard is in the building to your left.

### ■ From Points North

1. Take 1-95 South to Exit 17 (Broad Street/Pattison Avenue). Stay to the left.
2. Cross over Broad Street and then make a left onto Broad Street at the second light.
3. Enter the Navy Yard and turn left at the first light onto Crescent Drive.
4. Make a right at the stop sign. Jefferson at the Navy Yard is in the building to your left.

### ■ From Western Suburbs

1. Take 476 South to 1-95 North.
2. Take 1-95 North to Exit 17 (Broad Street/Pattison Avenue).
3. Turn left at the first light (Zinkoff Boulevard) and make an immediate left onto Broad Street.
4. Get in right lane (avoid the entrance to 1-95) and follow Broad Street into the Navy Yard.
5. Enter the Navy Yard and turn left at the first light onto Crescent Drive.
6. Make a right at the stop sign. Jefferson at the Navy Yard is in the building to your left.

### ■ From New Jersey via Walt Whitman Bridge

1. Cross the Walt Whitman Bridge.
2. After the toll booth, take Exit 349 (Broad Street/Sports Complex).
3. Turn left at the first light onto Broad Street.
4. Follow Broad Street approximately 1 mile to the Navy Yard.
5. Enter the Navy Yard and turn left at the first light onto Crescent Drive.
6. Make a right at the stop sign. Jefferson at the Navy Yard is in the building to your left.

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### ■ Public Transportation From Center City

You now have the option to utilize public transportation with access to the Navy Yard via free bus routes.

- The Navy Yard Express Shuttle runs from 10th and Filbert Streets to the Navy Yard.
- The Navy Yard Loop Shuttle runs all day from AT&T Station to the Navy Yard.

Once you exit the bus, walk a few hundred feet to 3 Crescent Drive. Visit [NavYard.org](http://NavYard.org) for schedules and maps.