JOEL W. LEVITT, M.D., F.A.C.S, F.A.A.P.
PEDIATRIC OTOLARYNGOLOGY
Charter Member of the American Society of Pediatric Otolaryngology
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Director of Pediatric Otolaryngology
769 Northfield Avenue, Suite LL2
Children's Hospital of New Jersey at NBIMC
West Orange, New Jersey 07052

DATE:_____

PATIENT'S NAME: _____
First Middle Last

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( )_____ Cell Phone: ( )_____

Age: _____ Birth Date: _____ Sex(M/F): _____

PRIMARY INSURANCE: (Mom or Dad Information)

Name: _____
First Middle Last

Occupation: _____ Employer: _____

Work Phone: ( )_____

Social Security: _____

Sex(M/F): _____ Date of Birth: _____

Insurance Name: _____

Insurance ID# : _____

Insurance Group# : _____

Insurance Employer: _____

Send Reports to Referring Doctor: _____

SECONDARY INSURANCE: (Mom or Dad Information)

Name: _____
First Middle Last

Occupation: _____ Employer: _____

Work Phone: ( )_____

Social Security: _____

Sex(M/F): _____ Date of Birth: _____

Insurance Name: _____

Insurance ID# : _____

Insurance Group# : _____

Insurance Employer: _____

Send Reports to Doctor: _____

Doctor's Address:_____

I certify that the above information is true to the best of my knowledge and I authorize the release of any medical information necessary to process the claim. I request payment of benefits to physician in accordance with program policy.

_____
Signature of Patient / Parent / Guardian

I have read and understand the HIPAA privacy provision given to me by Doctor Levitt

Reason for seeing the doctor today?

_____
_____
_____
_____

MEDICAL PROBLEMS - please check:

☐	Heart disease	☐	Kidney disease
☐	Heart murmur	☐	Jaundice
☐	Asthma	☐	Cancer
☐	Diabetes	☐	High Blood Pressure
☐	Blood disease	☐	OTHER _____

List Prescription Medications:

_____
_____
_____

List Over the counter Medications:

_____
_____
_____

HOSPITALIZATIONS? (EXPLAIN):

_____
_____
_____

ALLERGIC REACTIONS TO MEDICATIONS OR ANESTHESIA? ❑ Yes ❑ No
If yes, please explain

_____
_____

LIST KNOWN ALLERGIES:

_____
_____

Do you Bruise/Bleed Easily? ❑ Yes ❑ No If yes, please explain

_____
_____
_____

Does your religious belief prevent you from donating or receiving blood? ❑ Yes ❑ No
If yes, please explain

_____
_____