JOEL W. LEVITT, M.D., F.A.C.S, F.A.A.P.
PEDIATRIC OTOLARYNGOLOGY
Charter Member of the American Society of Pediatric Otolaryngology
www.drjoellevitt.com

Director of Pediatric Otolaryngology
769 Northfield Avenue, Suite LL2
Children's Hospital of New Jersey at NBIMC
West Orange, New Jersey 07052
Phone: (973) 731-2100

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

_____
_____