

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



Reason for seeing the doctor today?

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MEDICAL PROBLEMS - please check:

- |                          |               |                          |                     |
|--------------------------|---------------|--------------------------|---------------------|
| <input type="checkbox"/> | Heart disease | <input type="checkbox"/> | Kidney disease      |
| <input type="checkbox"/> | Heart murmur  | <input type="checkbox"/> | Jaundice            |
| <input type="checkbox"/> | Asthma        | <input type="checkbox"/> | Cancer              |
| <input type="checkbox"/> | Diabetes      | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | Blood disease | <input type="checkbox"/> | OTHER _____         |

List Prescription Medications:

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List Over the counter Medications:

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HOSPITALIZATIONS? (EXPLAIN):

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ALLERGIC REACTIONS TO MEDICATIONS OR ANESTHESIA?  Yes  No

If yes, please explain

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LIST KNOWN ALLERGIES:

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

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Does your religious belief prevent you from donating or receiving blood?  Yes  No

If yes, please explain

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