Charles C. Greene, MD, PhD
jacksonvilleENTsurgery.com

MAIN OFFICE	SATELLITE OFFICE	SATELLITE OFFICE	SATELLITE OFFICE	SATELLITE OFFICE
11512 Lake Mead Ave Ste #536	4131 University Blvd S #18	3890 Dunn Ave Ste #202	6484 Ft Caroline Rd	789 W. Duval St
Jacksonville, FL 32256	Jacksonville, FL 32216	Jacksonville, FL 32218	Jacksonville, FL 32277	Lake City, FL 32055
(904) 419-2054 (Ph)	(904) 419-2054 (Ph)	(904) 419-2054 (Ph)	(904) 419-2054 (Ph)	(904) 419-2054 (Ph)
(904) 419-2057 (Fax)	(904) 419-2057 (Fax)	(904) 419-2057 (Fax)	(904) 419-2057 (Fax)	(904) 419-2057 (Fax)

Confidential Patient Information Form

Form must be filled out completely to ensure correct claim processing.

SS#: _____ Name: _____
(Last) (First) (MI)

DOB: _____ Address: _____
(Street#) (City) (State) (Zip)

Home #: _____ Cell #: _____ Work #: _____

Language: _____ Ethnicity: _____ Race: _____

Employer: _____ Marital Status: _____ Employ Status: _____ Student: _____
(S, M, D, W) (FT, PT, Ret, N/A) (FT, PT)

Email address: _____ Emergency Contact: _____ Phone: _____

Referring Physician: _____ **Primary Care Physician** _____

Pharmacy Name, Phone#, Fax# and address: _____

Primary Ins Name: _____

Subscriber: _____ DOB: _____

SS#: _____ Employer: _____

Insurance ID: _____ Group Name & #: _____

Address for Insurance: _____

Secondary Ins Name: _____

Subscriber: _____ DOB: _____

SS#: _____ Employer: _____

Insurance ID: _____ Group Name & #: _____

Address for Insurance: _____

I understand that I am directly and primarily responsible to Jacksonville ENT Surgery for their customary fee for the services rendered to me. I realize that if my insurance company fails to pay or if there is any delay in paying Jacksonville ENT Surgery, it is my responsibility to pay my doctor's bill directly and promptly. I further understand and agree that if I fail to make timely payments to Jacksonville ENT Surgery, that I will be responsible for any and all reasonable cost of collection including filing fees as well as any reasonable attorney's fee(s).

For the services rendered, I authorize the release of any medical or other information necessary to process claims to my insurance carrier. This may include the diagnosis and records in the course of my examination or treatment. I also request payment of government benefits either to myself or the party who accepts assignment (Jacksonville ENT Surgery). I authorize payment of medical benefits to the physician who submits the claim. I agree to hold Jacksonville ENT Surgery harmless from any and all costs, liability and damages of and nature whatsoever including reasonable attorney's fees, resulting directly from the release of my medical records pursuant to this consent.

I understand the office may employ an Advanced Registered Nurse Practitioner (ARNP) or Physician Assistant (PA) and if I am scheduled with them, I am willing to see them instead of the doctor.

I hereby consent to and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. I consent to electronic access to my medication history.

This form was last modified on 11/1/2012. I acknowledge that I have read this authorization and fully understand its contents.

Signature: _____ Date: _____