



Charles C. Greene MD, PhD, PA
Phone: (904) 419-2054
Toll Free: (866) 419-2054
Fax: (904) 419-2057

Thank you for choosing to make an appointment at the office of Dr. Charles Greene. Please take a few minutes to fill out the following paperwork completely, prior to coming in for your appointment. If you have any questions please feel free to give us call at the number above. If you have access to a fax machine please fax your paperwork back to the office prior to your appointment. Thank you for your time and cooperation, we look forward to meeting you.

Sincerely,

Charles C. Greene MD, PhD and Staff

[Patient name]

Your appt is **[day, date @ time]**

At our **Kennerly Rd** office to see **[Practitioner]**

Pharmacy Name: _____

“” Address: _____ City _____ State ____ Zip Code _____

“” Phone: () _____ - _____

“” Fax: () _____ - _____

Primary Care Doctor: _____

“” Address: _____ City _____ State ____ Zip Code _____

“” Phone: () _____ - _____

“” Fax: () _____ - _____



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Patient Name: _____

DOB _____

Male _____ Female _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone#() _____ Cell# _____ Work# _____

Patient SS#: _____ Occupation: _____

Primary Insurance: _____

Ins. Phone: _____ ID#: _____

Group #: _____

Primary Insured: _____

DOB: _____

Secondary Insurance: _____

Ins. Phone: _____ ID#: _____

Primary Insured: _____

Group #: _____

Referral: YES/NO Referral #: _____ Referring Physician: _____

Emergency Contact: _____ Phone #: _____

Relationship to patient: _____



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IF PATIENT IS CHILD/MINOR

Mother's Name: _____

DOB: _____ **SS#** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #() _____ **Cell/Work#** _____

Father's Name: _____ **DOB:** _____ **SS#** _____

Address: _____ **Home Phone #**() _____

City: _____ **State:** _____ **Zip:** _____ **Cell/Work#** _____

Names of Brothers/Sisters:

Name: _____ **DOB:** _____ **Name:** _____ **DOB:** _____

Name: _____ **DOB:** _____ **Name:** _____ **DOB:** _____

Who are the legal guardians for this Child?

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

If other than parent, do you have guardianship paperwork? YES/NO *(Please bring copy to appointment)*

I AUTHORIZE THE FOLLOWING ADULTS TO BRING _____ TO DR. CHARLES GREENE FOR HEALTHCARE.
(CHILDS NAME)

Name: _____ **Relationship:** _____ **Phone#** _____

Name: _____ **Relationship:** _____ **Phone#** _____

Print Name: _____

Signature: _____ **Date** _____

(Office use) Witness by: _____ **Date** _____



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COMPREHENSIVE MEDICAL HISTORY

Please complete the following patient medical history information so that we may offer you/your child the proper medical care. Please mark where applicable for you or your child.

Patient Name: _____ **Date of Birth:** _____

PATIENT HISTORY: (Please circle any medical condition the patient has)

- | | | | |
|--------------------------|--------------------------------|---------------------|--------------|
| Seasonal Allergies | Asthma | ADD/ADHD | Diabetes |
| Bleeding disorder | TB | Emphysema | Hearing Loss |
| Recurrent ear infections | High B/P | Cancer | HIV/AIDS |
| Speech Delay | Seizures | Behavioral Problems | |
| Sickle Cell Anemia | Sickle Cell Trait | Acid Reflux | Sleep Apnea |
| Problems with Anesthesia | Recurrent Tonsil infections | | Stuffy Nose |
| Dizziness/Vertigo | Ringing in the ears (tinnitus) | | Heart Attack |
| Coronary Artery Disease | Thyroid Disease | Liver Disease | Hepatitis |
| RSV | Meningitis | Depression | Anxiety |
| Migraine Headaches | Sinusitis | | |
| Other _____ | | | |

SURGICAL HISTORY: (Please circle all that apply or fill in the blanks)

- | | | |
|-------------------------------------|------------------------|-----------------|
| Sinus Surgery | Ear Tubes/Ear Surgery | Thyroid Surgery |
| Nasal Surgery | Neck Surgery | Heart Surgery |
| Tonsillectomy | Adenoidectomy | Septoplasty |
| Salivary Gland Removal | Carotid Artery Surgery | Brain Surgery |
| Eye Surgery | Appendectomy | Gall Bladder |
| Cancer Surgery (type) _____ | | |
| Other Surgeries (please list) _____ | | |

FOOD ALLERGIES? Y N

KNOWN DRUG ALLERGIES? Y N

Drug name: _____ reaction: _____
Drug name: _____ reaction: _____
Drug name: _____ reaction: _____

ALL CURRENT MEDICATIONS (include over the counter medications):

FAMILY MEDICAL HISTORY: (If any of your parents, your child’s parents, siblings, or grandparents have the following diseases please circle and explain which relative)

DIABETES _____ HEART DISEASE _____
HIGH B/P _____ CANCER (type) _____
BLEEDING DISORDERS _____ EMPHYSEMA/TB _____
SICKLE CELL _____ SEIZURES _____
HEARING LOSS _____ THYROID PROBLEMS _____
DEVELOPMENTAL PROBLEMS _____ OTHER _____

SOCIAL HISTORY:

Does the patient participate in/is patient exposed to: (Please circle one)

Smoking Exposure: Y N Participates: Y N
Alcohol Exposure: Y N Participates: Y N Daily Weekend Rarely
Drugs Exposure: Y N Participates: Y N Type(s): _____
Pet Exposure: Y N Type(s): _____
Abuse Y N Type: _____

Does Patient Attend School/Day care? Y N

Grade level ? _____

School/ Day Care Attending? _____

Exercise: Type _____ Frequency _____

Developmental History: (for children only)

Pregnancy & Birth

Birth weight: _____

Please Circle

Vaginal or C-Section: _____

During Pregnancy Was.....

- | | | |
|---|----------|----------|
| 1. Mother treated for infection? | Y | N |
| 2. Child treated for infections? | Y | N |
| 3. Low Birth Weight? | Y | N |
| 4. Problems at Birth? | Y | N |
| 5. Prematurity? | Y | N |

PLEASE EXPLAIN IF YES TO ANY OF THE ABOVE:

REVIEW OF SYSTEMS (PLEASE CIRCLE ALL THAT APPLY)

FEVER	Y	N	WEIGHT LOSS	Y	N
ANOREXIA	Y	N	HEADACHE	Y	N
HEART TROUBLE	Y	N	BLURRED VISION	Y	N
PALPITATIONS	Y	N	DIZZINESS	Y	N
CHEST PAIN	Y	N	STROKE	Y	N
HIGH B/P	Y	N	COUGH	Y	N
FREQUENT THROAT CLEARING	Y	N	HEARTBURN	Y	N
DIFFICULTY SWALLOWING	Y	N	HOARSENESS	Y	N
RINGING IN EARS	Y	N	HEARING LOSS	Y	N
SNEEZING	Y	N	POST NASAL DRIP	Y	N
ITCHY/WATERY EYES	Y	N	RUNNY NOSE	Y	N
NASAL OBSTRUCTION	Y	N	RASH/ECZEMA	Y	N
ABDOMINAL PAIN	Y	N	SLEEP APNEA	Y	N
EASY BRUISING	Y	N	SNORING	Y	N

I acknowledge the above medical history to be true to the best of my ability.

Signature

date



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PATIENT PRIVACY PRACTICE ACKNOWLEDGEMENT AND CONSENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and in-directly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I have reviewed and I consent to the above statements.

Patient Name: _____ Telephone: () _____ - _____

Patient/guardian Signature: _____ Date: _____

PATIENT CONTACT

All calls regarding your appointments, diagnostic or surgical scheduling will be made to your home phone number. If you would like us to contact you at an alternate phone number, please indicate that number here: _____

Location: _____

_____ I hereby authorize this medical practice to contact me by telephone and if I am not present, they may leave a message on my answering machine/voicemail or with (name of individual) _____

-OR-

_____ If you prefer that we do NOT leave messages on your answering machine.
Initial _____

OFFICE USE ONLY

Signed form received by (print): _____ Initials: _____

Acknowledgement refused:

Reason for refusal: _____



Charles C. Greene, MD, PhD, PA
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Jacksonville, Fl 32216
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Appointment Cancellation Policy

Missing an appointment or canceling an appointment (this includes clinic appointments and operative procedure appointments) **after 4:30pm the business day before** your scheduled appointment will result in a **\$50.00 clinic** or **\$100.00 operative procedure** cancellation fee assessed to your account.
This fee is not covered by insurance.

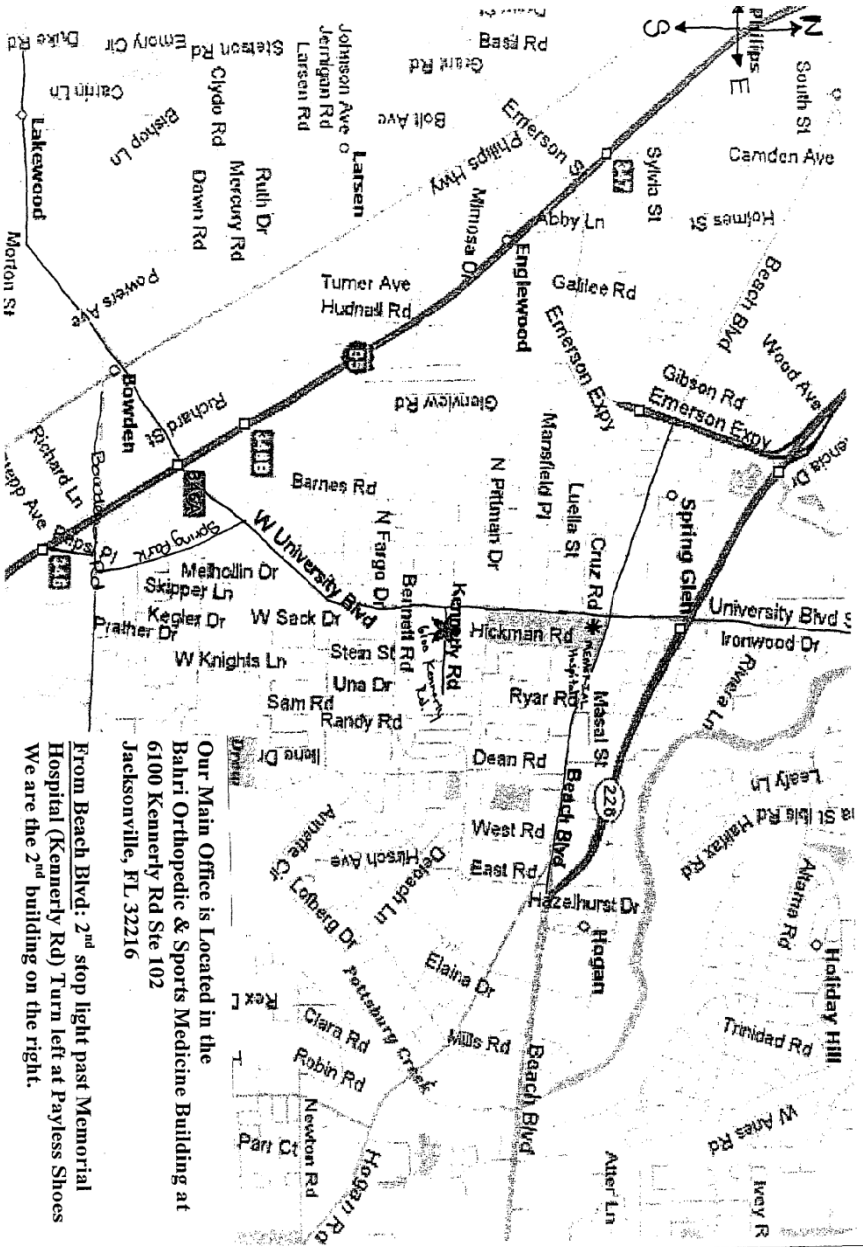
I acknowledge that I have read and understand the above statement.

Signature

Witness

Date

Date



Our Main Office is located in the Bahri Orthopedic & Sports Medicine Building at 6100 Kennedy Rd Ste 102 Jacksonville, FL 32216

From Beach Blvd: 2nd stop light past Memorial Hospital (Kennery Rd) Turn left at Payless Shoes We are the 2nd building on the right.

From I-95: 5th stop light from freeway (Kennery Rd) Turn right. We are the 2nd building on the right.