Glenn W. Knox, MD, FACS, PSC
Ear, Nose and Throat
Otology and Neurotology
Ear and Sinus Surgery
Hearing and Balance Testing
Diplomate, American Board of Otolaryngology

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Jacksonville, Florida 32223
904-292-9777
904-292-1313 fax

This form must be completed in its entirety. TODAY'S DATE______________

PATIENT'S NAME __________________________ __________________________ ________________
(LAST) (FIRST) (MIDDLE)
SOCIAL SECURITY # ______________________________ DATE OF BIRTH ______________________

ADDRESS____
(STREET) (APT #)

____
(CITY) (STATE) (ZIP CODE)
HOME PHONE(____)______________________ ALTERNATE PHONE (____)____________________

PATIENT'S EMPLOYER___________________________________ WORK PHONE # ______________
(PLEASE INDICATE IF STUDENT OR RETIRED)

IN CASE OF AN EMERGENCY, WHOM SHOULD WE CONTACT?_____________________________
TELEPHONE #________________ RELATIONSHIP_____________________________

NAME AND ADDRESS OF YOUR PRIMARY CARE DOCTOR_________________________________
NAME OF THE DOCTOR THAT REFERRED YOU TO OUR OFFICE___________________________
NAME OF ANY OTHER DOCTORS THAT YOU SEE____
Please be sure that the above information is accurate and complete. Please give us a DOCTOR'S NAME, not a group practice name or nurse practitioner's name.

NAME OF YOUR PRIMARY INSURANCE COMPANY____

NAME OF YOUR SECONDARY INSURANCE COMPANY_____________________________________

IF YOU ARE COVERED UNDER THE POLICY OF A SPOUSE, PARENT ETC. PLEASE GIVE US THE FOLLOWING INFORMATION ABOUT THEM:

NAME___________________________________ DATE OF BIRTH_____________________________

RELATIONSHIP TO YOU____

ADDRESS (IF DIFFERENT FROM ABOVE)____

SOCIAL SECURITY #________________________________ PHONE # ___________________________

EMPLOYER____ WORK # __________________________

<u>WE MUST MAKE A COPY OF YOUR INSURANCE CARD AS WELL AS YOUR DRIVER'S LICENSE.</u>

YOUR SIGNATURE INDICATES THAT YOU ARE AWARE OF THE FOLLOWING:
I AM AWARE THAT PAYMENT IS REQUIRED WHEN SERVICES ARE RENDERED.
LIFETIME SIGNATURE AUTHORIZATION FOR MEDICARE. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENTS BENEFITS EITHER TO MYSELF OR THE PARTY WHO ACCEPTS ASSIGNMENT.
INSURANCE AUTHORIZATION: I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE ATTENDING PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED.

PLEASE SIGN AND DATE ____