North Fulton Ear, Nose, and Throat Associates, Inc.

Roy Schottenfeld, M.D.
Raymond L. Schettino, M.D.
Joel Hoffman, M.D.
Mark J. Yanta, M.D.

PATIENT INFORMATION (Informacion Sobre los Pacientes)

PLEASE PRINT, COMPLETELY FULLY AND RETURN TO FRONT DESK

Circle One: Mrs. Ms. Miss Mr. Child

Patient's Name (**Su Nombre Completo la paciente**):______________________________

Apellidos First Middle

Address (**Su Direccion**):______________________________

City (**Su Ciudad**):______________ State:________ Zip Code (**Su Zona Postal**):________

Home Phone (**Numero de Telefono**):______________ Marital Status (**Su estado civil**) (circle one) **S M Other**

Social Security No. Patient (**Su numero de Social Security**):______________P__________

Date of Birth (**Su Fecha de Nacimiento**)______________ Age:________ Sex (**Su Sexo**): **M F**

Employer (**Lugar donde trabaja**):______________ Work Phone (**Numero de telefono**):__________

Address (**Direccion**):______________________________

Calle Ciudad State

El nombre de la persona responsible de pagar la cuenta	Los nombres de sus padres / esposo (a)
Nombre______________	Nombre______________
Su Fecha de nacimiento______________	Su Fecha de nacimiento______________
Numero de Social Security ______________	Numero de Social Security ______________
Lugar de trabaja ______________	Lugar de trabaja ______________
Work Phone (Numero de telefono):______________	Work Phone (Numero de telefono):______________
Direccion donde trabaja: ______________	Direccion donde trabaja: ______________

Authorization to treat minor child (Su permiso para examen)______________ (Circle One) Mother Father Guardian

Person to notify in case of Emergency [not at the same address] (El Nombre de la persona llamar en el emergencia):__________

Phone Number (Numero de telefono)______________ Relationship:__________ Employer:__________

Who is your Primary Care Physician? (El Doctor su familia) ______________ Numero de telefono:__________

Referred By: ______________ Numero de telefono: ______________

INSURANCE INFORMATION: I also acknowledge that the physicians of North Fulton Ear, Nose, and Throat may or may not be a part of the provider network for my insurance company, and that it is my responsibility to verify that North Fulton Ear, Nose and Throat are participating providers in my network. Please Give Your Insurance Card(s) To The Receptionist So We May Keep A Copy On File. All professional services rendered are charged to the patient/guardian. Receipts will be provided for insurance reimbursement. However, the patient is responsible for all fees regardless of insurance coverage.

It is also customary to pay for services when rendered unless other arrangements have been made in advance with our business manager. In order to keep our charges as low as possible, we expect payment at time of service, unless other arrangements are made. Do you wish to pay for the visit today by Cash Check or Credit Card (circle one) ?

I hereby authorize Dr. Schottenfeld/Schettino/Hoffman/Yanta to furnish all information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Date (la Fecha) ______________ **Signature (Firmar):**______________________________