

Roy S. Schottenfeld, M.D. • Raymond L. Schettino, M.D., F.A.C.S. • Mark J. Yanta, M.D.

Circle one: Mrs. Ms. Miss Mr.

Patient Name: _____
Last First Middle

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Marital Status (circle one) S M Other Sex: (circle one): M F

Patient Social Security No.: _____ Date of Birth: _____ Age: _____

Employer: _____

INSURANCE POLICY HOLDER INFORMATION	PARENT, GUARDIAN OR SPOUSE INFORMATION
Insured Name: _____	Name: _____
Date of Birth: _____	Date of Birth: _____
Social Security #: _____	Social Security #: _____
Employer: _____ Work Phone: _____	Employer: _____ Work Phone: _____
Cell Phone: _____	Cell Phone: _____
Relationship to Patient: _____	Relationship to Patient: _____

Person to notify in case of emergency (Not at same address) Name: _____

Phone Number: (home) _____ (work) _____ Relationship: _____

Who is your Primary Care Physician? _____ Phone: _____

Name of physician or other source who referred you to our practice: _____

Physician: _____ Other: _____ Phone: _____

INSURANCE INFORMATION: I acknowledge that the physicians of North Fulton Ear, Nose and Throat Associates may not be a part of the provider network for my insurance plan. I understand it is my responsibility to verify this information with my insurance company.

In order to keep our charges as low as possible, we expect payment for services, deductible, co-insurance and co-pay at the time of service unless arrangements have been made in advance with the business manager. I will pay my portion of the services today by: Cash Check or Credit Card (check one)

I hereby authorize the physicians of NFENT Assoc. to furnish the necessary information concerning my illness and treatment to my insurance company, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by my insurance. My signature will also serve as authorization to treat my child if the patient is a minor

Date: _____ Signature: _____ Relationship: _____

HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information below to the best of your ability.

Patient Name: _____ Birth Date: _____ Date: _____
Patient #: _____

Chief complaint: _____

History of present illness:

Location _____
(Where is the pain/problem?)

Quality _____
(Example: normal vs. abnormal color, activity, etc.)

Severity _____
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe.)

Duration _____
(How long have you had the pain/problem? Or, when did it start?)

Timing _____
(Does the pain/problem occur at a particular time?)

Context _____
(Where were you at the onset of this pain/problem?)

Associated signs/symptoms _____

Modifying factors _____

(What other associated problems have you been having?)

(What makes the pain/problem worse or better? Or, have you had previous episodes?)

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles no yes	Anemia no yes	Back Trouble no yes	Hepatitis no yes
Mumps no yes	Bladder infections no yes	High Blood Pressure no yes	Ulcer no yes
Chickenpox no yes	Epilepsy no yes	Low Blood Pressure no yes	Kidney Disease no yes
Whooping Cough no yes	Migraine headaches no yes	Hemorrhoids no yes	Thyroid Disease no yes
Scarlet Fever no yes	Tuberculosis no yes	Date of last chest x-ray _____	Bleeding Tendency no yes
Diphtheria no yes	Diabetes no yes	Asthma no yes	Any other disease no yes
Smallpox no yes	Cancer no yes	Hives or Eczema no yes	(please specify)
Pneumonia no yes	Polio no yes	AIDS or HIV+ no yes	_____
Rheumatic Fever no yes	Glaucoma no yes	Infectious Mono no yes	_____
Heart Disease no yes	Hernia no yes	Bronchitis no yes	_____
Arthritis no yes	Blood or Plasma Transfusion no yes	Mitral Valve Prolapse ... no yes	_____
Venereal Disease no yes		Stroke no yes	_____

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications (include nonprescriptions) _____

Patient social history

Marital status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____
Use of alcohol: Never _____ Rarely _____ Moderate _____ Daily _____
Use of tobacco: Never _____ Previously, but quit: _____ Current packs/day: _____
Use of drugs: Never _____ Type/frequency: _____
Excessive exposure at home or work to: Fumes: _____ Dust: _____ Solvents: _____
Airborne particles: _____ Noise: _____

Family medical history

	Age	Diseases	If deceased, Cause of Death
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Review of Systems: Please indicate any personal history below

Constitutional Symptoms

Good general health lately.....No Yes
 Recent weight change.....No Yes
 FeverNo Yes
 Fatigue.....No Yes
 Head acheNo Yes

Eyes

Eye disease or injuryNo Yes
 Wear glasses/contact lenses.....No Yes
 Blurred or double visionNo Yes

Ears/Nose/Mouth/Throat

Hearing loss.....No Yes
 Ringing in earsNo Yes
 Earaches or drainage.....No Yes
 Chronic sinus problems or rhinitis.....No Yes
 Nose bleeds.....No Yes
 Mouth soresNo Yes
 Bleeding gums.....No Yes
 Bad breath or bad taste.....No Yes
 Sore throat or voice changeNo Yes
 Swollen glands in neck.....No Yes

Cardiovascular

Heart troubleNo Yes
 Chest pain or angina pectoris.....No Yes
 Palpitation.....No Yes
 Shortness of breath w/walking
 or lying flatNo Yes
 Swelling of feet, ankles, or hands..No Yes

Respiratory

Chronic or frequent coughs.....No Yes
 Spitting up bloodNo Yes
 Shortness of breath.....No Yes
 WheezingNo Yes

Gastrointestinal

Loss of appetite.....No Yes
 Change in bowel movements.....No Yes
 Nausea or vomiting.....No Yes
 Frequent diarrheaNo Yes
 Painful bowel movements
 or constipation.....No Yes
 Rectal bleeding or blood in stool..No Yes
 Abdominal painNo Yes

Genitourinary

Frequent urinationNo Yes
 Burning or painful urination.....No Yes
 Blood in urine.....No Yes
 Change in force or strain
 when urinatingNo Yes
 Incontinence or dribbling.....No Yes
 Kidney stones.....No Yes
 Sexual difficultyNo Yes
 Male—testicle painNo Yes
 Female—pain with periodsNo Yes
 Female—irregular periodsNo Yes
 Female—vaginal dischargeNo Yes
 Female—# of pregnancies _____
 Female—# of miscarriages..... _____
 Female—date of last pap smear .. _____

Musculoskeletal

Joint painNo Yes
 Joint stiffness or swellingNo Yes
 Weakness of muscles or joints.....No Yes
 Muscle pain or cramps.....No Yes
 Back painNo Yes
 Cold extremities.....No Yes
 Difficulty walking.....No Yes

Integumentary (skin, breast)

Rash or itchingNo Yes
 Change in skin colorNo Yes
 Change in hair or nailsNo Yes
 Varicose veins.....No Yes
 Breast painNo Yes
 Breast lumpNo Yes
 Breast dischargeNo Yes

Neurological

Frequent or recurring headache ...No Yes
 Light headed or dizzy.....No Yes
 Convulsions or seizures.....No Yes
 Numbness or tingling sensations.No Yes
 TremorsNo Yes
 Paralysis.....No Yes
 Head injuryNo Yes

Psychiatric

Memory loss or confusionNo Yes
 Nervousness.....No Yes
 Depression.....No Yes
 InsomniaNo Yes

Endocrine

Glandular or hormone
 problemNo Yes
 Excessive thirst or urination.....No Yes
 Heat or cold intoleranceNo Yes
 Skin becoming dryerNo Yes
 Change in hat or glove size.....No Yes

Hematologic/Lymphatic

Slow to heal after cutsNo Yes
 Bleeding or bruising easilyNo Yes
 AnemiaNo Yes
 Phlebitis.....No Yes
 Past transfusion.....No Yes
 Enlarged glandsNo Yes

Allergic/Immunologic

History of skin reaction or other adverse
 reaction to:
 Penicillin or other antibiotics....No Yes
 Morphine, Demerol,
 or other narcoticsNo Yes
 Novocain or other anesthetics.No Yes
 Aspirin or other pain remedies No Yes
 Tetanus antitoxin
 or other serumsNo Yes
 Iodine, Merthiolate
 or other antiseptic.....No Yes
 Other drugs/medications :

Known food allergies:

Environmental allergies:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

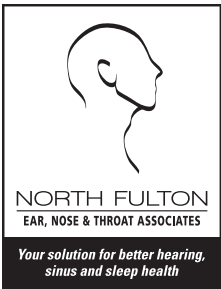
 Signature of patient, parent, or guardian

 Date

Doctor's Review

 Signature of Doctor

 Date



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REQUEST FOR RELEASE OF MEDICAL RECORDS

Please print your doctor's name, address, phone number and fax number, if known. If information is unavailable, a first and last name of the doctor is acceptable.

**TO COMPLY WITH HIPAA REGULATIONS REGARDING
MINIMUM NECESSARY, PLEASE FORWARD A COPY OF
THE PORTION OF MY MEDICAL RECORDS THAT PERTAINS
TO: _____.**

(Diagnosis)

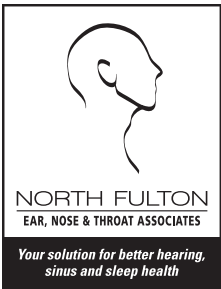
**North Fulton ENT Associates
2500 Hospital Blvd., Ste. 450
Roswell, GA 30076
(770) 343-8675 Fax#: (770) 343-6297**

Patient name: _____

Date of birth: _____

Signature: _____

Relationship to patient: _____



Roy S. Schottenfeld, M.D. • Raymond L. Schettino, M.D., F.A.C.S. • Mark J. Yanta, M.D.

Dear Patient:

Because the physicians in our practice are surgeons, it is possible your treatment will include surgical procedures in the office and/or a hospital or facility. If you need to change or cancel your scheduled surgery, you must do so within 14 business days of the scheduled procedure or you may be subject to a \$100.00 fee charged to your account or deducted from any deposits that might have been collected. If the rescheduling or cancellation is due to illness or death in the immediate family, the fee will be waived.

There may also be times when your physician needs to order testing outside of our office. This may include blood work, biopsies, specimen exams, cultures or diagnostic testing. Please be aware that you will receive a separate bill from the facilities performing these tests. If your insurance plan requires you to use a particular lab, please inform the nurse so we can utilize the appropriate facility. Our office cannot take responsibility for any specimen sent to the wrong lab.

Please note our physicians have an ownership interest in certain our patient surgical facilities. Depending on your medical needs, you may be referred to one of these facilities. Your ongoing care is not conditioned on your acceptance of this referral. You have the right to obtain the services from the facility to which you are referred or from a health care provider of your choice. The ownership interest information is as follows:

Children's Healthcare of Atlanta Surgery Center at Meridian Mark Plaza, LCC
5445 Meridian Mark Road, Suite 340
Atlanta, GA 30342

Dr. Roy Schottenfeld *Dr. Raymond Schettino *Dr. Mark Yanta

Atlanta Outpatient Surgery Center
5505 Peachtree Dunwoody Road, Suite 150
Atlanta, GA 30342

Dr. Roy Schottenfeld *Dr. Raymond Schettino* Dr. Mark Yanta

If you have any questions regarding this notice, please ask the receptionist.

I have read and understand the above notice.

Signature of Patient or Authorized Person

Date