

North Fulton Ear, Nose, and Throat Associates, Inc.
Roy Schottenfeld, M.D.
Raymond L. Schettino, M.D.
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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 responsable 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):** _____