NorthFultonENT
EAR, NOSE & THROAT ASSOCIATES

Roy S. Schottenfeld, M.D.
Bryant T. Conger, M.D.
Raymond L. Schettino, M.D.
Sunny Singh Khichi, 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

Insured Name: _____
Date of Birth: _____
Social Security #: _____
Employer: _____ Work Phone: _____
Cell Phone: _____
Relationship to Patient: _____

PARENT, GUARDIAN OR SPOUSE INFORMATION

Name: _____
Date of Birth: _____
Social Security #: _____
Employer: _____ Work Phone: _____
Cell Phone: _____
Relationship to Patient: _____

Pharmacy Phone Number: _____

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.

Date: _____

Patient Name: _____ Birth 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 _____
(What other associated problems have you been having?)

Modifying factors_____
(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			Mitral Valve Prolapse	no	yes			
Venereal Disease	no	yes	Transfusion	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
Fever ..... No Yes
Fatigue ..... No Yes
Head ache ..... No Yes

☐ **Eyes**

Eye disease or injury ..... No Yes
Wear glasses/contact lenses ..... No Yes
Blurred or double vision ..... No Yes

☐ **Ears/Nose/Mouth/Throat**

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

☐ **Cardiovascular**

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

☐ **Respiratory**

Chronic or frequent coughs ..... No Yes
Spitting up blood ..... No Yes
Shortness of breath ..... No Yes
Wheezing ..... No Yes

☐ **Gastrointestinal**

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

☐ **Genitourinary**

Frequent urination ..... No Yes
Burning or painful urination ..... No Yes
Blood in urine ..... No Yes
Change in force or strain when urinating ..... No Yes
Incontinence or dribbling ..... No Yes
Kidney stones ..... No Yes
Sexual difficulty ..... No Yes
Male—testicle pain ..... No Yes
Female—pain with periods ..... No Yes
Female—irregular periods ..... No Yes
Female—vaginal discharge ..... No Yes
Female—# of pregnancies ..... _____
Female—# of miscarriages ..... _____
Female—date of last pap smear .. _____

☐ **Musculoskeletal**

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

☐ **Integumentary (skin, breast}**

Rash or itching ..... No Yes
Change in skin color ..... No Yes
Change in hair or nails ..... No Yes
Varicose veins ..... No Yes
Breast pain ..... No Yes
Breast lump ..... No Yes
Breast discharge ..... No 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
Tremors ..... No Yes
Paralysis ..... No Yes
Head injury ..... No Yes

☐ **Psychiatric**

Memory loss or confusion ..... No Yes
Nervousness ..... No Yes
Depression ..... No Yes
Insomnia ..... No Yes

☐ **Endocrine**

Glandular or hormone problem ..... No Yes
Excessive thirst or urination ..... No Yes
Heat or cold intolerance ..... No Yes
Skin becoming dryer ..... No Yes
Change in hat or glove size ..... No Yes

☐ **Hematologic/Lymphatic**

Slow to heal after cuts ..... No Yes
Bleeding or bruising easily ..... No Yes
Anemia ..... No Yes
Phlebitis ..... No Yes
Past transfusion ..... No Yes
Enlarged glands ..... No Yes

☐ **Allergic/Immunologic**

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics .... No Yes
Morphine, Demerol, or other narcotics ..... No Yes
Novocain or other anesthetics . No Yes
Aspirin or other pain remedies No Yes
Tetanus antitoxin or other serums ..... No 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., Suite 450
Roswell, GA 30076
(770) 343-8675
FAX#: (770) 343-6297

Patient Name: _____

Date of Birth: _____

Signature: _____

Relationship to Patient: _____

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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 you 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 outpatient 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 service from the facility to which you are referred or from a health care provider of your choice. The ownership interest is as follows:

Children's Healthcare of Atlanta Surgery Center at Meridian Mark Plaza, LLC
5445 Meridian Mark Rd, Suite 340
Atlanta, GA 30342
Roy Schottenfeld, M.D. * Raymond Schettino, M.D.

Atlanta Outpatient Surgery Center
5730 Glenridge Drive, NE, Suite 400
Atlanta, GA 30328
Roy Schottenfeld, M.D.

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

NorthFultonENT
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Bryant T Conger, MD Sunny S Khich, MD

FINANCIAL RESPONSIBILITY

A **deductible** is a specified portion of your bill that a patient must pay before an insurance company will pay his/her claim. While generally a co-payment is required for an office visit, some services and all procedures performed in the office will require the patient to meet the deductible for full or partial payment, depending on your insurance contract. Procedures performed in the office are considered the same as surgery by insurance companies and are billed as such.

Additionally, your Office Visit today may include the use of a scope for diagnostic purposes. This is considered a diagnostic procedure, which will be coded to your insurance company as a **SURGICAL PROCEDURE**. Depending on your particular policy, your insurance company will pay all, part, or none of the cost of the procedure. **It is your responsibility to be aware of the terms and conditions of your policy prior to procedure being performed.** Any charges not covered by the insurance carrier will be the responsibility of the patient.

YOU HAVE THE RIGHT TO REFUSE THE DIAGNOSTIC PROCEDURE. By signing this consent for, you are acknowledging these terms.

_____ _____

Signature of Patient or Authorized Person **Date**

APPOINTMENT CANCELLATION POLICY

Your appointment will be confirmed by phone call, e-mail or text prior to your scheduled appointment. If you have scheduled your appointment within 24 hours, you will not receive a confirmation call.

Please call us at 770-343-8675 by 2:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00 p.m. on Friday. If prior notification is not given, you will be charged $100 for the missed appointment.

I hereby acknowledge that I am aware and accept the financial responsibility for fees assessed to my account for failing to provide the required cancellation notice of any scheduled appointments at North Fulton ENT. I understand that this fee is not reimbursable by my insurance carrier.

_____ _____

Signature of Patient or Authorized Person **Date**