NORTH ATLANTA ENT & ALLERGY

Patient Registration

Personal information

Today's date _____ Referred by _____

Last name _____ First name _____ Middle name _____

Street (mailing) address _____

City _____ State _____ Zip _____

Date of birth _____ Age _____ Social Security number _____

Marital status: ☐ single ☐ married ☐ divorced Sex: ☐ male ☐ female

Race: ☐ White ☐ African ☐ American ☐ Asian ☐ Hawaiian/Pacific Islander

☐ American Indian/Alaska Native ☐ other (specify) _____

Ethnicity: ☐ Hispanic/Latino ☐ not Hispanic/Latino ☐ unknown

Preferred language: ☐ English ☐ Spanish ☐ other (specify) _____

Emergency contact name _____ Phone _____

Pharmacy name _____ Phone _____

Employer name _____ Phone _____

Contact information

Number	Contact	Message	Number	Contact	Message
Home	☐	☐	Mobile	☐	☐
Work	☐	☐	Other	☐	☐

E-mail address _____

Insurance information

Primary insurance _____ Phone _____

Subscriber name _____

Subscriber number _____ Group number _____

Billing address _____

City _____ State _____ Zip _____

Secondary insurance (if applicable) _____ Phone _____

Subscriber name _____

Subscriber number _____ Group number _____

Billing address _____

City _____ State _____ Zip _____

Financial authorization

I authorize my insurance benefits to be paid directly to the physician, and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan.

Signature of patient or guardian _____ Date of signature _____

Print name _____

4150 Deputy Bill Cantrell Memorial Dr. Suite #260 Cumming, GA 30040
o:770.292.3045 • f: 770.292.3046 • naenta2012@gmail.com • naenta.com