

MYLES K KRIEGER, MD, FACS

Otolaryngology-Facial Plastics-Aesthetic Medicine
 Medical Director of Brainchild Institute

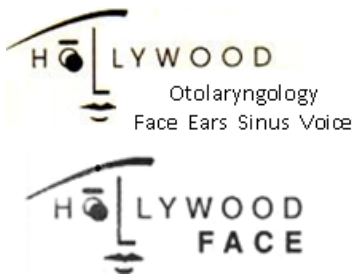
Patient Name: Last: _____ **First:** _____
M.I. _____
Date of Birth: _____ **Age:** _____ **Sex:** € M € F
E-mail: _____ **Patient's SSN #** _____ - _____ - _____
Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____
Home Address: _____ **Apt #** _____
City: _____ **State:** _____ **Zip:** _____
Status: € Minor € Single € Married € Separated € Divorced € Partnered € Widowed
Spouse/Partner's Name: _____ **Cell Phone:** _____ **Work Phone:** _____
Employer: _____
Occupation: _____
Emergency Contact: _____ **Phone Number:** _____ **Relationship:** _____
Referred by: _____ **Primary MD:** _____
Primary Insurance: _____ **Insured Name:** _____ **DOB:** _____
Relationship: _____
Secondary Insurance: _____ **Insured Name:** _____ **DOB:** _____
Relationship: _____

If patient is a MINOR (under 18) or you are the LEGAL GUARDIAN/Power of Attorney complete below:

RESPONSIBLE PARTY WITH PATIENT TODAY:

Mother's Name: _____ **SSN #** _____ - _____ - _____ **Date of Birth:** _____
Cell Phone: _____ **Home Phone:** _____ **Work Phone:** _____
Father's Name: _____ **SSN #** _____ - _____ - _____ **Date of Birth:** _____
Cell Phone: _____ **Home Phone:** _____ **Work Phone:** _____
Legal Guardian: _____ **SSN #** _____ - _____ - _____ **Date of Birth:** _____
Cell Phone: _____ **Home Phone:** _____ **Work Phone:** _____

Financial Policies



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Fees for office visits and procedures are payable when the service is rendered. If you must cancel an appointment, please give us 24 hours notice. You will be charged a penalty fee if you do not comply with this requirement. I authorize payment of my insurance benefits directly to Myles K. Krieger, M.D. for all services furnished. I authorize Myles K. Krieger, M.D. to release to my insurance carrier any information needed to determine these benefits payable for related services. In the event it is necessary for Myles K. Krieger, M.D., Hollywood ENT, d.b.a. Hollywood FACE, Hollywood EARS and Hollywood Voice to pursue payment directly from me, I will pay all additional costs of collection (1.5% monthly finance charge on balances 30 days past due, 50% collection handling fee(s), collection agency fees, court costs and reasonable attorney's fees). **I understand that I am totally responsible for services and/or products charges.** I consent to the photographing of the procedures(s) to be performed, including appropriate portions of my body, for medical education, scientific or educational purposes, provided my name is not revealed.

Signature of Responsible Party: _____ **Print**
Name: _____

Today's Date: _____ **Relationship to Patient:** Self Mother Father
 Legal Guardian

NAME: _____ **TODAY'S**
DATE: _____

Please state in a few words the reason for your visit or cosmetic concern:

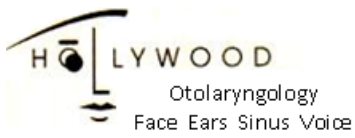
**RECENT TESTS (include
 tion):**

<input type="checkbox"/> CT Scan of	<input type="checkbox"/> PET Scan	<input type="checkbox"/> MRI of Brair	<input type="checkbox"/> XRAY of	<input type="checkbox"/> LABWORK	<input type="checkbox"/> OTHER

HISTORY

Do you have any known allergies? _____ If yes, to what? _____
 Do you have any bleeding problems or clot failure? _____
 How much alcohol do you drink daily (number of drinks)? _____ In the past? _____
 Do you currently smoke? _____ For how long? _____ How many packs daily? _____
 Did you quit smoking? _____ When did you quit? _____ How many packs daily? _____ For how long? _____

Hospital Admissions/Surgeries even if it has nothing to do with this visit: (Year, Reason and/or Diagnosis)



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