DR. CRAIG J. BRANDNER

DIPLOMATE AMERICAN BOARD OF ORAL & MAXILLOFACIAL SURGERY

PATIENT INFORMATION

Mr. Mrs. Ms. Dr. ____

First Name MI Last Name Nickname

Mailing Address: ____

Street City State Zip

Sex: Male Female Birth Date: ____________ Age: ______ Soc Sec #: ____________________

Marital Status: Married Single Divorced Widowed

Home Phone ( ) ____________ Cell Phone ( ) ____________ **E-Mail** ____________

If Employed: Full Time Part Time Retired **Employer:** ____________ **Bus. Tel.:** ____________

Dentist: ____________ Medical Doctor: ____________ Referred By: ____________

IN CASE OF EMERGENCY, CONTACT:

Name: ____________ Relationship: ________ Daytime Tel: ( ) ________ Secondary Tel: ( ) ________

Who will be responsible for your account? Self Father Mother Other

IF PATIENT IS A MINOR: Legal Parent/Guardian present with patient at today's appointment :

Name: ____________ Relationship: ________ S.S. #: ________ Married or Single ____ Birthday ________

Address: ____

Street City State Zip

Tel.: ( ) ____________ Employer: ____________ Bus. Tel.: ( ) ____________

PATIENT PRIVACY INFORMATION

Can we leave a message at: **Home:** Yes No **Work:** Yes No **Cell:** Yes No

I hereby authorize Dr. Brandner and/or his staff to communicate my appointment, status, insurance, surgical information and/or medical condition to the following individual(s):

Name: ____________ Relationship: ____________ Phone Number: ____________

Name: ____________ Relationship: ____________ Phone Number: ____________

Signature of patient: X ____________________ **Date:** X ____________
(Parent or Guardian if minor)

IS THIS VISIT RELATED TO AN ACCIDENT? (if not, skip to the next section)

Automobile: Yes No Work Related: Yes No Other: Yes No Date of accident: ____________

Insurance company handling this claim: ____________ Tel. #: ( ) ____________ Claim #: ____________

Where and How did accident happen: ____

FEES AND PAYMENTS

We make every effort to keep down the cost of your surgical care. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form. All fees are the responsibility of the patient or responsible party. As a courtesy to you, our office will file your insurance claim for you. Patient agrees to this contract for all charges incurred from emergency care prior to today's visit and for future fees associated with care given. However, should the balance not be paid in 45 days after service is rendered, the outstanding balance is past due and your responsibility. Interest will accrue monthly at 1.5% on all past due accounts. I also understand that if my account is forwarded to collection, 33% will be added to my past due balance. Any and all attorney's fees, costs and/or expenses arising out of, resulting from or incurred in connection with the collection of amounts past due and payable to Dr. Brandner for professional services rendered, including but not limited to the cost of litigation, shall be borne by the patient.

Signature of patient: X ____________________ **Date:** X ____________
(Parent or Guardian if minor)

AUTHORIZATION

I authorize Dr. Brandner and his staff to perform a medical/dental examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

Signature of patient: X ____________________ **Date:** X ____________
(Parent or Guardian if minor)

I hereby acknowledge that a copy of this office's Notice of Privacy Practices and this office's Financial Policy has been made available to me. I have been given the opportunity to ask any questions I may have regarding these Notices.

Signature of patient: X ____________________ **Date:** X ____________
(Parent or Guardian if minor)

DR. CRAIG J. BRANDNER

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INSURANCE INFORMATION

DENTAL

PRIMARY DENTAL INSURANCE COMPANY

Ins. Co. Name: ____________________

Tel.: (   ) ____________________

Member ID#: ____________ Group #: ________

Policyholder Information:
Name: ____________ Relationship: ________

Birth Date: ____________ S.S. #: ____________

Address: ____________________

SECONDARY DENTAL INSURANCE COMPANY

Ins. Co. Name: ____________________

Tel.: (   ) ____________________

Member ID#: ____________ Group #: ________

Policyholder Information:
Name: ____________ Relationship: ________

Birth Date: ____________ S.S. #: ____________

Address: ____________________

ADDITIONAL DENTAL INSURANCE COMPANY

Ins. Co. Name: ____________________

Tel.: (   ) ____________________

Member ID#: ____________ Group #: ________

Policyholder Information:
Name: ____________ Relationship: ________

Birth Date: ____________ S.S. #: ____________

Address: ____________________

ADDITIONAL DENTAL INSURANCE COMPANY

Ins. Co. Name: ____________________

Tel.: (   ) ____________________

Member ID#: ____________ Group #: ________

Policyholder Information:
Name: ____________ Relationship: ________

Birth Date: ____________ S.S. #: ____________

Address: ____________________

MEDICAL

PRIMARY MEDICAL INSURANCE COMPANY

Ins. Co. Name: ____________________

Tel.: (   ) ____________________

Member ID #: ____________ Group #: ________

Policyholder Information:
Name: ____________ Relationship: ________

Birth Date: ____________ S.S. #: ____________

Address: ____________________

SECONDARY MEDICAL INSURANCE COMPANY

Ins. Co. Name: ____________________

Tel.: (   ) ____________________

Member ID #: ____________ Group #: ________

Policyholder Information:
Name: ____________ Relationship: ________

Birth Date: ____________ S.S. #: ____________

Address: ____________________

ADDITIONAL MEDICAL INSURANCE COMPANY

Ins. Co. Name: ____________________

Tel.: (   ) ____________________

Member ID #: ____________ Group #: ________

Policyholder Information:
Name: ____________ Relationship: ________

Birth Date: ____________ S.S. #: ____________

Address: ____________________

ADDITIONAL MEDICAL INSURANCE COMPANY

Ins. Co. Name: ____________________

Tel.: (   ) ____________________

Member ID #: ____________ Group #: ________

Policyholder Information:
Name: ____________ Relationship: ________

Birth Date: ____________ S.S. #: ____________

Address: ____________________

AUTHORIZATION

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to Craig J. Brandner, A.P.C. of the benefits otherwise payable to me.

Signature of patient: **X** ____________________ **Date:** **X** ____________
(Parent or Guardian if minor)