DR. CRAIG J. BRANDNER
DR. JOSHUA S. BRANDNER

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. All fees are the responsibility of the patient or responsible party. Effective August 9, 2019, we opted out of medicare and no medicare claims can be filed. 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
DR. JOSHUA S. BRANDNER

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)