HEIDI BRANDENBURG
DDS

3948 West 50th Street | Suite 201 | Edina, MN 55424 | 952 922 8787 | hb-dds.com

Patient Information / Adult

The following confidential information is important for the dentist to know planning your dental care. Please answer each question as completely as you can. Thank you.

Patient Name	Date of Birth	
Address	Cell Phone #	
City, State, Zip	Home Phone #	Preferred Contact Method
Email Address	Social Security #	
Employer	Position	Work Phone #
Name of person to contact in case of emergency	Phone #	
How did you find out about our dental office?		

Account Information

Person Responsible for Account (address and phone, if different from above)	Social Security #
If you will be using Dental Insurance, please provide the following:	
Dental Insurance Company	Group #
Subscriber Name	Subscriber Date of Birth
Subscriber Employer	Subscriber ID#

Health Information—Dental

Previous Dentist		**Do any of the following apply to you now or in the past?**					
Address		Toothache	Yes	No	Mouth sores	Yes	No
Last Dental Exam	Last Dental X-Rays	Cold sensitivity	Yes	No	Swelling in the mouth	Yes	No
Reason for this visit		Heat sensitivity	Yes	No	Unpleasant taste	Yes	No
What do you feel is the present condition of your mouth?		Pressure sensitivity	Yes	No	Food Collects	Yes	No
Are you interested in regular dental care?		Sweet sensitivity	Yes	No	Grinding/Clenching	Yes	No
How often do you brush your teeth?		Bleeding gums	Yes	No	Jaw joint noise	Yes	No
What type of toothbrush do you currently use? Manual? Electric?		Gums hurt	Yes	No	Locked jaw	Yes	No
How often do you floss your teeth?		Gum treatment	Yes	No	Improper bite	Yes	No
If you could change anything about your smile, what would it be?		Loose teeth	Yes	No	Braces	Yes	No
		Bad breath	Yes	No	Unattractive teeth	Yes	No
		Other? Please explain:					

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Health Information—Medical	Patient Name					
Physician's Name	Are you allergic to:					
Address	Penicillin	Yes	No	Local Anesthetic	Yes	No	Other Allergies:
Phone	Codeine	Yes	No	Latex	Yes	No	
Are you currently under the care of a physician? If yes, explain.	List all medications or drugs (and dosages) that you are taking:						
Have you ever had a serious illness or accident? If yes, explain.							
Women—are you pregnant? If yes, how long?							

Do any of the following apply to you now or in the past?

Heart Disease	Yes	No	Thyroid Problem	Yes	No	Tuberculosis/Lung Disease	Yes	No	Tumors	Yes	No
Rheumatic Fever	Yes	No	Jaundice	Yes	No	Asthma/ Hay Fever	Yes	No	Radiation Therapy	Yes	No
Heart Murmur	Yes	No	Hepatitis	Yes	No	Sinus Problems	Yes	No	Osteopenia/ Osteoporosis	Yes	No
Congenital Heart Defect	Yes	No	Ulcers/ Reflux	Yes	No	Epilepsy/ Seizures	Yes	No	Prosthetic Joint/ Implant	Yes	No
Abnormal Blood Pressure	Yes	No	Diabetes	Yes	No	Fainting Spells	Yes	No	HIV/AIDS	Yes	No
Abnormal Bleeding	Yes	No	Excessive Thirst/ Urination	Yes	No	Chemical Dependency	Yes	No	HPV	Yes	No
Stroke	Yes	No	Anemia	Yes	No	Mental Health Care	Yes	No	Tobacco User	Yes	No

Any additional information? Please explain:

The information is correct to the best of my knowledge. I authorize the performance of diagnostic and therapeutic procedures, and the administration of such medications as may be necessary for proper dental care.

Patient Signature	Date
D.D.S. Signature	Date

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Patient Information / Minor

The following confidential information is important for the dentist to know planning your dental care. Please answer each question as completely as you can. Thank you.

Patient Name	Date of Birth
Address	Cell Phone #
City, State, Zip	Home Phone #
Email Address	Preferred Contact Method
Name of person to contact in case of emergency	Phone #
How did you find out about our dental office?	

Account Information

Person Responsible for Account (address, if different from above)		Social Security #
Employer	Position	Work Phone #

If you will be using Dental Insurance, please provide the following:

Dental Insurance Company	Group #
Subscriber Name	Subscriber Date of Birth
Subscriber Employer	Subscriber ID#

Health Information—Dental

Previous Dentist		**Do any of the following apply to your child now or in the past?**					
Address		Toothache	Yes	No	Mouth sores	Yes	No
Child's Last Dental Exam	Child's Last Dental X-rays	Cold sensitivity	Yes	No	Swelling in the mouth	Yes	No
Reason for this visit		Heat sensitivity	Yes	No	Tobacco user	Yes	No
What do you feel is the present condition of your child's mouth?		Pressure sensitivity	Yes	No	Grinding/Clenching	Yes	No
Are you interested in ongoing dental care for your child?		Sweet sensitivity	Yes	No	Jaw joint noise	Yes	No
How often does your child brush their teeth?		Bleeding gums	Yes	No	Locked jaw	Yes	No
What type of toothbrush does your child currently use? Manual? Electric?		Sensitive gums	Yes	No	Improper bite	Yes	No
How often does your child floss their teeth?		Unattractive teeth	Yes	No	Braces	Yes	No
What concerns do you have about your child's smile? Teeth?		Other? Please explain:					

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Health Information—Medical	Patient Name
Physician's Name	Is your child allergic to:
Address	Penicillin Yes No Local Anesthetic Yes No
Phone	Codeine Yes No Latex/Other Yes No
Is your child currently under the care of a physician? If yes, explain.	List all medications or drugs (and dosages) your child is taking:
Has your child ever had a serious illness or accident? If yes, explain.	

Do any of the following apply to your child now or in the past?

Heart Disease	Yes	No	Thyroid Problem	Yes	No	Tuberculosis/Lung Disease	Yes	No	Tumors	Yes	No
Rheumatic Fever	Yes	No	Jaundice	Yes	No	Asthma/ Hay Fever	Yes	No	Radiation Therapy	Yes	No
Heart Murmur	Yes	No	Hepatitis	Yes	No	Sinus Problems	Yes	No	Frequent Ear Infections	Yes	No
Congenital Heart Defect	Yes	No	Ulcers / Reflux	Yes	No	Epilepsy/ Seizure	Yes	No	How often?		
Abnormal Blood Pressure	Yes	No	Intestinal Issues	Yes	No	Fainting Spells	Yes	No			
Abnormal Bleeding	Yes	No	Excessive Thirst/ Urination	Yes	No	Chemical Dependency	Yes	No			
Diabetes	Yes	No	Anemia	Yes	No	Mental Health Care	Yes	No			

Any additional information? Please explain:

The information is correct to the best of my knowledge. I authorize diagnostic and therapeutic procedures, and the administration of such medications as may be necessary for proper dental care of my minor child/guardian.

Parent or Guardian Signature	Date
D.D.S. Signature	Date

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PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy of this Practice not to release confidential medical and health information regarding your treatment to family members or friends, except for 1) parent/legal guardian; 2) other persons authorized by the patient; 3) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment); 4) in emergency situations, or 5) as otherwise permitted by the Health Insurance Portability and Accountability Act (HIPAA).

If you anticipate that you will need or want your medical or health information to be provided to family members, friends, or caretakers/babysitters, please sign below so that we can release that information to that person. If you do not want any of your medical or health information provided to a family member or friend, please circle the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. If you wish to add names later on, please confirm this in writing.

You may cancel this authorization to the extent allowed by law. If you do, you understand that the doctor or Practice may have already released information about you after you gave permission. You understand that cancelling this authorization would not prohibit any release of information by the Practice in reliance on your original authorization.

If you wish to cancel or change this agreement, please issue a letter in writing to this Practice.

	Health Care Information	Financial Information
Spouse_____	☐ Yes ☐ No	☐ Yes ☐ No
Parent_____	☐ Yes ☐ No	☐ Yes ☐ No
Other_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	☐ Yes ☐ No	☐ Yes ☐ No

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not want to be contacted in a certain way.

I hereby request the following means of contact only_____

PRINTED NAME:_____

Patient/Parent/Guardian Signature_____Date:_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name_____Telephone_____

Address _____

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out our treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our Notice of Privacy Practices accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. These changes may apply to any of your protected health information that we maintain.

You may obtain another copy of our Notice of Privacy Practices, including revisions, at any time by contacting:
Privacy Officer: Telephone: 952-922-8787 • 3948 W. 50th St., Suite 201, Edina, Minnesota 55424

CONSENT DOES NOT EXPIRE AFTER ONE YEAR. By signing this Consent form, I am explicitly giving informed consent for the release of health records and health information for the purposes listed herein and that this Consent does not expire after one year for 1) the release of health records to a provider who is being advised or consulted with in connection with the releasing provider's current treatment of myself; or, 2) the release of health records to an accident and health insurer, health service plan corporation, health maintenance organization, or third-party administrator for purpose of payment of claims, fraud investigation, or quality of care review and studies.

RIGHT TO REVOKE: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Privacy Officer listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent. You may obtain a revocation of consent form upon request.

FOR TELEPHONE, TEXT, EMAIL COMMUNICATIONS

☐ By checking this box, I consent to the following: This Dental Practice or its service provider may contact me to provide health care information such as appointment reminders about treatment, payment, my insurance, my account, using prerecorded or artificial prerecorded voice or telephone equipment that may be capable of automatic dialing. This Dental Practice may:

☐ Call me ☐ Email me ☐ Text me

SIGNATURE
I have received a copy of this practice's Notice of Privacy Practices and have had the full opportunity to read and consider the contents of this Consent form. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature_____Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative Name:_____
NOTE: A parent is considered a Personal Representative for a minor under the HIPAA Privacy Regulations.

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

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DDS

NOTICE OF PRIVACY PRACTICES

EFFECTIVE OCTOBER 10, 2015

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

In the event that Minnesota State Regulations pertaining to privacy are stricter than Federal Regulations, this Practice will follow the Minnesota State Regulations. If you have any questions about this notice, please contact our Privacy Officer. We are required by law to maintain the privacy of protected health information and to tell you of our legal duties. Disclosures of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. We use and disclose your information for the purposes of treatment, payment and healthcare operations and for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Unless you give us an additional written authorization, we cannot use or disclose your health information for any reason except as described in this Notice. You may request a copy of our Notice at any time. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by accessing our website; or by calling the office and requesting that a revised copy be sent to you in the mail; or asking for one at the time of your next appointment.

USES AND DISCLOSURES OF HEALTH INFORMATION

TREATMENT: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

PAYMENT: We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract (Business Associate Agreement) that contains terms that will protect the privacy of your protected health information. Effective March 31, 2013, our Business Associate Agreements have been amended to provide that all of the HIPAA security administrative safeguards, physical safeguards, technical safeguards and security policies, procedures, and documentation requirements apply directly to the business associate and their subcontractors.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities as allowed by the regulations. We will receive your authorization for all treatment and health care operations communications where we receive financial remuneration for making the communications from a third party whose product or service is being marketed. For example, your name and address may be used to send you a newsletter about our practice and the services we offer.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use you health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Disclosures to other providers within health care entities when necessary for current treatment do not require an Authorization.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

PERSONS INVOLVED IN CARE: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications to third parties without your prior written authorization. We will receive your authorization for all treatment and health care operations communications where we receive financial remuneration for making the communications from a third party whose product or service is being marketed.

FUNDRAISING ACTIVITIES: If we engage in any fundraising activities, you have a right to opt out of receiving further fundraising communications.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

NATIONAL SECURITY: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or a law enforcement official having lawful custody of protected health information of an inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders such as voicemail, messages, postcards, or letters.

PATIENT RIGHTS

ACCESS: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. We may charge you a fee for each page and fee for staff time to locate and copy your health information and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

DISCLOSURE ACCOUNTING: You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other that treatment, payment or healthcare operations as described in the Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

USES AND DISCLOSURES. Uses and disclosures of PHI will be made only with prior written authorization from the individual. Disclosures that constitute a sale of PHI will only be made with prior written authorization from the individual. Other uses and disclosures not described in the Notice of Privacy Practices will be made only with prior written authorization from the individual.

RESTRICTION: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement except in an emergency.

You have the right to restrict information given to your third party payer or health plan if you fully pay for the services out of your pocket.

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

AMENDMENT: You have the right to request that we amend your health information. (Your request must be in writing), and it must explain why the information should be amended. We may deny your request under certain circumstances.

SECURITY BREACH: You have a right to or will receive notification of breaches of your unsecured protected health information. The notification will occur by first class mail within 60 days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of protected health information. There are three exceptions to the definition of what a breach is. An impermissible use or disclosure of PHI is presumed to be a breach unless we can demonstrate that there is a low probability that the PHI has been compromised. The notification requirements under this section apply only if it does not fall into one of the three exceptions or if we cannot demonstrate that there is a low probability that the PHI has been compromised. If we are required to provide notice to you, the notice will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

Not every impermissible use or disclosure of protected health information constitutes a reportable breach. The determination of whether an impermissible breach is reportable hinges on whether there is a low probability that the PHI has been compromised. In order to determine whether there is a low probability that your PHI has been compromised, we will conduct a risk assessment using the four factor analysis outlined in the Omnibus Final Rule that became effective March 26, 2013. For example, if a laptop computer was stolen and later recovered and a forensic analysis shows that the PHI on the computer was never accessed, viewed, acquired, transferred, or otherwise compromised, we could determine that the

information was not actually acquired by an unauthorized individual even though the opportunity existed, and, therefore, you would not need to be notified of the breach. The key to determining whether you will need to be notified of an unauthorized use or disclosure of your PHI is whether there is a low probability that your PHI has been compromised.

ELECTRONIC NOTICE: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

TELEPHONE, TEXT, EMAIL COMMUNICATIONS: Upon receiving your consent, the Practice or its service provider may contact you to provide health care information such as appointment reminders about treatment, payment, insurance, your account, using prerecorded or artificial prerecorded voice or telephone equipment that may be capable of automatic dialing.

COMPLAINTS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information.

We will not retaliate in any way if you choose to file a complaint with U.S. Department of Health and Human Services.

Submit complaints to: Privacy Officer
3948 W. 50th. St., Suite 201
Edina, Minnesota 55424
Telephone: 952-922-8787
Fax: 952-922-5595

Website: www.hb-dds.com

HEIDI BRANDENBURG
DDS

INFORMED CONSENT

YOU ARE OUR FIRST PRIORITY.

You deserve quality, long lasting dental care and you deserve fair compensation from your dental benefit plan. Treatment plans designed by Dr. Brandenburg ensure quality, yet conservative, long term dental health. We believe you and your comprehensive care come first.

PLANS VARY.

In most cases, your employer- the purchaser of your dental benefit plan- selects the range of benefits available to you. Some plans cover 30-100% of treatment costs while others are limited and cover only specific services. As your partner in dental health care, we encourage you to please read through you benefit plan to familiarize yourself with your benefits regarding preventative, basic and major coverage. We will process your claim quickly and help you receive the benefits promised to you within your benefit plan contract.

BENEFITS MISUNDERSTOOD.

Dental benefit companies will lead you to believe there is a standard fee for dental work called the UCR fee, meaning "Usual, Customary and Reasonable." Research shows UCR fees vary as much as 136% within the individual insurance company. In most cases, the UCR fee is developed according to the cost of the plan purchased by your employer.

Both dental fees and benefit plan reimbursement dollars vary. Forty years ago, dental benefit companies provided a yearly maximum allowance of $1500.00, which covered most necessary treatment. As health care costs and the costs of benefit plans have increased, the yearly maximum allowances have not increased accordingly.

Your comprehensive care is our priority. We hold ourselves to a high standard of comprehensive care. The treatment plan we designed for you has been individualized to your needs. In other words, the care we provide is not usual and customary. Low reimbursement can be the result of poor benefit contracts. If you feel your benefits are inadequate, it is most effective if you discuss this with your employer.

TERMS

Typical terms used by carriers include "Pre-Estimate and Pre-Authorization." These terms vary and in most cases are not necessary to complete before treatment.

To ensure you receive maximum benefits from your dental benefit plan, it is critical for you to know your plan's definition of these terms. We recommend you read your benefit plan and become familiar with your specific term requirements.

PROVIDING YOUR DENTAL BENEFIT PLAN WITH INFORMATION IS A SERVICE WE GLADLY PROVIDE.

Assisting you in receiving benefits from your dental benefit plan is a service we gladly provide. Our office will be responsible for the submission and processing of your claims.

It is essential our clients to fully understand their dental benefit plan information and coverage. Your dental benefit plan may not cover the cost of your necessary dental treatment. You are responsible for unpaid balances. We ask you to provide the necessary plan information at the time of service, (identification number, group number, name address and phone number of the benefit plan), so your claim can be processed correctly and efficiently. We thank you for your assistance; please call if you have any questions.

Patient or Guardian Signature:_____ Date:_____

HEIDI BRANDENBURG
DDS

RECORD RELEASE

Patient Name: _____ Date of Birth:_____

Address:_____

I request and authorize all copies of any and all clinical records including previous FMX and Panorex within the last five years and BWX within the last two years to the following:

HEIDI BRANDENBURG, D.D.S.
3948 West 50 th Street, Suite 201
Edina, MN 55424
E-mail: frontdesk@hb-dds.com

Phone: 952-922-8787
Fax: 952-922-5595

Time and date of next appointment: _____

Signature: _____Date:_____

Relationship to patient: _____