PATIENT INFORMATION

Date: ___ / ___ / ____

Greenbrook
DENTAL GROUP S.C.

First name: _____

Last name: _____

Please circle preference: Mr Mrs Ms Dr Atty ___

Preferred name: _____
(How do you prefer we address you?)

ADDRESS and PHONE

Street _____

City _____

State _____ Zip _____

□ Home phone: ( ) - _____ - _____

□ Work phone: ( ) - _____ - _____

□ Cell phone: ( ) - _____ - _____

Email: _____

PERSONAL

Date of Birth: ___ / ___ / _____ Sex: □ M □ F

SSN: _____

Insurance coverage through self/ spouse/both

Employer_____

SPOUSE

First name_____

Last name_____

Date of birth_____

Employer_____

Caregiver/Parent/Guardian contact

Whom should we ask for consent? _____

Name: _____

Relation: _____

Emergency contact: ( ) - _____ - _____
(If different from above)

□ Patient is dependent youth or minor
□ Patient is dependent elderly
□ Other: _____

Whom may we thank for referring you?

Name: _____

Address/City: _____

DENTAL INSURANCE (staff will affix card copy below)

RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

I authorize release of all information required to process dental insurance claims and permit a copy of this authorization to be used in place of the original assignment.

I assign to Greenbrook Dental Group, S.C. any benefits I am entitled from my insurance company for services provided and understand I am financially responsible for all charges regardless of type or level of insurance coverage.

_____ _____
Signature (Patient or Parent/Guardian) Date

Greenbrook Dental Group, S.C. WISCONSIN CONSENT

Purpose: This form is to obtain an individual's written permission under Wisconsin law for (a) our use of the individual's dental care records to carry out treatment, payment activities, and health care operations, and (b) our disclosure of the individual's dental care records to carry out treatment, payment activities, and health care activity.

SECTION A: Individual giving consent.

Name: _____

Patient Name: (If different than above) _____

Address: _____

Phone: _____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

Effect of Declining Consent: This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.

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

SECTION B: The uses and disclosures being authorized.

Our Use of Dental Health Information: By signing this form, you will consent to our use of your dental care records, to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice.

Persons Involved in Care. By signing this form, you will consent to our use of your dental care records to the following persons, including those involved in your care or payment for that care. Please list the person(s) you would like involved in your care or payment for that care.

We may use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person acting on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of protected health information.

Our Disclosure of Medical Information. By signing this form, you will consent to our disclosure of your dental care records to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice, and to our disclosure of your dental care records for disaster relief purposes as permitted by law.

SECTION C: Revocation.

Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at any time by giving written notice of revocation to the Contact Office listed below. Revocation of this consent will not affect any action we took in reliance on this authorization before we received your written notice of revocation. We may decline to treat you or to continue treating you if you revoke this consent.

Contact Office: Greenbrook Dental Group, S.C.
Telephone: (262) 782-4860
Address: 13780 W. Greenfield Ave. Suite 780 Brookfield, WI 53005

INDIVIDUAL'S SIGNATURE:

I, _____, have had full opportunity to read and consider the contents of this consent. I understand that, by signing this form, I am confirming my written permission for the disclosure of my protected health information, as described in this form.

Signature: _____ Date: _____

If this consent is signed by a personal representative/parent on behalf of the individual, complete the following:

Personal Representative's/Parent Name: _____

Relationship to Individual: _____

PATIENT/GUARDIAN INFORMATION

Greenbrook
DENTAL GROUP S.C

Date: ___ / ___ / _____

First name: _____

Last name: _____

Date of Birth: ___ / ___ / _____ Sex: □ M □ F

Preferred name: _____
(How do you prefer we address you?)

Parent/Guardian contact

Whom should we ask for consent? _____

Name: _____

Relation: _____

Emergency contact: ( ) - _____ - _____
(If different from above)

Street _____

City _____

State _____ Zip _____

□ Home phone: ( ) - _____ - _____

□ Work phone: ( ) - _____ - _____

□ Cell phone: ( ) - _____ - _____

Email: _____

SSN: _____

Insurance coverage through self/ spouse/both

Employer_____

SPOUSE

First name_____

Last name_____

Date of birth_____

Employer_____

Whom may we thank for referring you?

Name: _____

Address/City: _____

DENTAL INSURANCE (staff will affix card copy below)

RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

I authorize release of all information required to process dental insurance claims and permit a copy of this authorization to be used in place of the original assignment.

I assign to Greenbrook Dental Group, S.C. any benefits I am entitled from my insurance company for services provided and understand I am financially responsible for all charges regardless of type or level of insurance coverage.

_____ _____
Signature (Patient or Parent/Guardian) Date

Greenbrook Dental Group, S.C. WISCONSIN CONSENT

Purpose: This form is to obtain an individual's written permission under Wisconsin law for (a) our use of the individual's dental care records to carry out treatment, payment activities, and health care operations, and (b) our disclosure of the individual's dental care records to carry out treatment, payment activities, and health care activity.

SECTION A: Individual giving consent.

Name: _____

Patient Name: (If different than above) _____

Address: _____

Phone: _____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

Effect of Declining Consent: This consent is a condition of your treatment by us.
If you decide not to sign this consent, we may decline to treat you.

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

SECTION B: The uses and disclosures being authorized.

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Persons Involved in Care. By signing this form, you will consent to our use of your dental care records to the following persons, including those involved in your care or payment for that care. Please list the person(s) you would like involved in your care or payment for that care.

We may use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person acting on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of protected health information.

Our Disclosure of Medical Information. By signing this form, you will consent to our disclosure of your dental care records to carry out treatment, payment activities, and health care operations as set forth in our Privacy Practices Notice, and to our disclosure of your dental care records for disaster relief purposes as permitted by law.

SECTION C: Revocation.

Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at any time by giving written notice of revocation to the Contact Office listed below. Revocation of this consent will not affect any action we took in reliance on this authorization before we received your written notice of revocation. We may decline to treat you or to continue treating you if you revoke this consent.

Contact Office: Greenbrook Dental Group, S.C.
Telephone: (262) 782-4860
Address: 13780 W. Greenfield Ave. Suite 780 Brookfield, WI 53005

INDIVIDUAL'S SIGNATURE:

I, _____, have had full opportunity to read and consider the contents of this consent. I understand that, by signing this form, I am confirming my written permission for the disclosure of my protected health information, as described in this form.

Signature: _____ Date: _____

If this consent is signed by a personal representative/parent on behalf of the individual, complete the following:

Personal Representative's/Parent Name: _____

Relationship to Individual: _____

GREENBROOK DENTAL GROUP, S.C.

Get Acquainted Questionnaire: Confidential

So that we may treat you safely and effectively,
please answer all questions fully.

Updates:	w/ initials
___/___/___	_____
___/___/___	_____
___/___/___	_____
___/___/___	_____
___/___/___	_____

(office use only)

Name _____ Age _____ Date of Birth ____/____/____

MEDICAL HISTORY

When was your last physical exam? _____ Reason for exam? _____

Are you seeing a physician at this time? *yes / no* If so, for what? _____

Physician's name: _____ Party to notify in case of emergency: _____

Please list any medications (prescription or non-prescription) you are taking, and what they are for:

_____ _____ _____

_____ _____ _____

If you take more medications than fit on this page, please let us copy your physician's list or use the back of this page.

Are you allergic, or do you react to anything (drugs, food, etc.)? *yes / no* If so, what? _____

_____

Do you now, or have you ever had: (check only if **yes**)

- □ Arthritis Type: _____
- □ Diabetes
- □ Asthma
- □ Tuberculosis
- □ Heart problems/murmur
- □ Rheumatic fever
- □ Heart valve problems
- □ Need for antibiotics before dental procedures
- □ Pacemaker
- □ High blood pressure
- □ Pain in chest on exertion
- □ Dementia / Alzheimer's
- □ Abnormal bleeding
- □ Anemia / blood transfusion
- □ Osteoporosis / bone issues
- □ Sleep apnea or disorder
- □ AIDS or HIV
- □ Artificial Joint: _____
- □ Do you smoke? What? _____ How much? /day
- □ Hepatitis / Jaundice
- □ Liver disease
- □ Thyroid problem
- □ Chronic pain in: _____
- □ Acid Reflux / GERD
- □ Heart burn
- □ Nervous disorder/ psychiatric care
- □ Syndrome/Disease/Disorder that is not listed here (name): _____
- □ Malignancy or tumor Location: _____
- □ Radiation therapy Location: _____
- □ (female) Is there any chance you could be pregnant
- □ History of drug/alcohol abuse
- □ Fainting spells
- □ Epilepsy / Seizures

DENTAL HISTORY

What is your main problem / reason for coming? _____

Do you currently have dental related pain? *yes / no* _____

How do you feel about the condition of your teeth? _____

How do you feel about your past dental experiences? _____

When was your last dental visit? _____ Do you have any recent X-rays (≤ 2 yrs old) *yes / no*

Do you now, or have you ever had: (check if only **yes**)

HABITS/MISC:
- □ Clenching
- □ Grinding *day / night*
- □ Night guard or splint
- □ Jaw, neck, ear pain
- □ Cold sores / canker sores
- □ Gagging problems
- □ Problems with anesthetic

DISEASE:
- □ Any recent decay
- □ Decay around old fillings
- □ Dry mouth
- □ Root Canal Work
- □ Periodontal (Gum) disease
- □ Gum surgery
- □ Regular cleanings

CROWNS/BRIDGES:
- □ Broken teeth from chewing
- □ Broken teeth from trauma
- □ Crown on any tooth
- □ Any fixed bridge(s)
- □ Broken/failed crown
- □ Broken/failed bridge
- □ Orthodontics (braces)

REMOVABLE DEVICES:
- □ Removable partial denture
- □ Complete Denture
- □ Reline
- □ Broken denture
- □ Dental implant(s)
- □ Missing teeth
- □ Teeth bleached

HYGIENE AND DIET HISTORY

How often do you brush? _____ per day/week What kind of toothpaste? _____

Do you eat or drink between meals? yes / no Do you use dental floss? yes / no / occasionally

On average, how many times per day do you eat or drink anything other than water (snacks, coffee, soda, etc. + meals): _____

What other oral hygiene products do you use? _____

How often do you consume citrus fruits or carbonated beverages? _____ per day / week

____/____/____ _____

Today's date Your signature

Thank you for taking time to complete this form honestly and accurately!

GREENBROOK DENTAL GROUP, S.C.

Health History Update

To treat you safely, please answer all questions fully

Print Name: _____ DOB: _____

When was your last physical exam? _____ Reason for exam? _____

Are you seeing a physician at this time? *Yes / No* If yes, for what? _____

Physician name: _____

Do you require antibiotics before dental procedures? *Yes / No*

If yes, Prescribing physicians name: _____ Reason? _____

Person to notify in case of emergency: _____ Phone _____

Please list any medications (prescription or non-prescription) you are taking, and what they are for:

_____

_____

_____

(If you take more meds than fit on this page, please let us copy your physician's list or use the back of this form)

Are you allergic, or do you react to anything (drugs, food, etc.)? *Yes / No* If yes, what?

_____

_____

Do you now, or have you ever had: (check only if **yes**)

□ Do you smoke? What? _____ How much_____ /day □ Arthritis Type: _____ □ Diabetes □ Asthma □ Tuberculosis □ Heart problems/murmur □ Rheumatic fever □ Heart valve problems □ Pacemaker □ Pain in chest on exertion □ High blood pressure	□ Dementia / Alzheimer's □ Abnormal bleeding □ Anemia / blood transfusion □ Osteoporosis / bone issues □ Sleep apnea or disorder □ AIDS or HIV □ Artificial Joint: _____ □ Hepatitis / Jaundice □ Liver disease □ Thyroid problem □ Chronic pain in: _____ □ Acid Reflux / GERD □ Heart burn	□ Malignancy or tumor Location: _____ □ Radiation therapy Location: _____ □ (Female) Is there any chance you could be pregnant? □ History of drug/alcohol abuse □ Fainting spells □ Epilepsy / Seizures □ Nervous disorder/Psychiatric Care □ Syndrome/Disease/Disorder that is not listed here (name) _____

_____ Signature

____/____/____ Date

Thank you for taking time to complete this form honestly and accurately!

Greenbrook
DENTAL GROUP, S.C.

A note to our Patients:

The Federal Government requires lots of "fine print" in the "Notice of Privacy Practice" which is posted in the reception area (copies available at the desk). We can sum it up much more simply: **We have never, and will never, share or release any information about you to anyone else without your permission, or as required by a legal subpoena.** Period.

We do ask your written permission to send information to your insurance carrier specifically related to pre-estimate of dental benefits, or for claims following treatment. Unless you have any questions, please sign off on the two statements that follow, so we are in compliance with the new law:

1. I have read, and received a copy (if desired) of the "Notice of Privacy Practices" of Greenbrook Dental Group, S.C.

2. Having read the "Notice of Privacy Practices", I authorize Greenbrook Dental Group, S.C., and consent to the use, disclosure, and release of information to carry out treatment, pre-determine benefits, and submit claims for payment to my insurance carrier.

_____ _____/_____/_____

Signature of patient or responsible parent date

GREENBROOK DENTAL GROUP, S.C.
13780 W. GREENFIELD AVENUE
BROOKFIELD, WI 53005
(262) 782-4860

Thank you for choosing Greenbrook Dental Group. Our mission is to deliver the best and most comprehensive dental care available in a caring, comfortable environment. We believe that everyone benefits when financial expectations are understood prior to receiving treatment. In that spirit, we would like to share with you our financial policy:

FINANCIAL POLICY

At Greenbrook, full payment is expected when services are rendered. For major work, if you choose not to make full payment at the time of service, we require 1/2 payment at the onset of treatment, and the final 1/2 at the insert/completion appointment. In an effort to make the cost of optimal dental care as easy and manageable for our patients as possible, we offer several payment options:

- CASH OR CHECK – If you **do not** have dental insurance, a 5% discount will be extended when paid in full on *same day* as treatment is completed (up to $5,000.00 in treatment fees).
- CREDIT CARD OR DEBIT – We accept all major credit cards. Because we pay a fee for the service, the 5% discount does not apply.
- In Office Payment Plans – If you need to set up a payment plan, it must be pre-approved by the Office Manager prior to start of treatment. We are unable to extend a payment arrangement beyond three months.
- CARE CREDIT – If you are interested in extending your payments beyond what is offered in our office, you may be eligible for a one year interest free loan. It requires a credit application be completed and approved. Contact information is available through our office, but all arrangements are made directly between patient and Care Credit.

Patients with Dental Insurance:
We will submit a pre-estimate of treatment and any claims for service to your insurance company at no charge. Dental insurance rarely covers the total cost of treatment, and we often encounter long delays in receiving insurance payments. Therefore in all major cases, ½ of the fee is due when treatment begins and the balance is due at the completion appointment, less the estimated insurance payment. *Patients are responsible for full balance, regardless of what insurance may pay.*

If you have any questions or concerns, please do not hesitate to ask. We are always happy to answer your questions and help in any way we can.

Please note: The patient is responsible for all fees on delinquent accounts that go to collections

_____ _____

Patient Signature Date