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: ______________________________