ROBERT B. HURLEY, DDS
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Grand Rapids, MI 49525
616-364-9451

PLEASE PRINT CLEARLY • PRINT CLEARLY • PLEASE PRINT CLEARLY • PRINT CLEARLY

Date: _____

Patient Name: _____
Address: _____
City, State, Zip: _____
E-mail Address: _____

SS #: _____ Birthdate: _____
Age: _____ Sex: Male ☐ Female ☐

Employer: _____
Work Phone: _____

Home Phone: _____
Cell Phone: _____

Responsible Party: _____
Relationship to Patient: _____

Address: _____
City, State, Zip: _____
E-mail Address: _____

SS#: _____ Birthdate: _____
Age: _____ Sex: Male ☐ Female ☐

Employer: _____
Work Phone: _____

Home Phone: _____
Cell Phone: _____

Emergency Contact Person: _____ Home Phone: _____
Relationship to Patient: _____ Cell Phone: _____
Work Phone: _____

Former Dentist: _____ Former Dentist City and State: _____
Last Dental Visit Date: _____ Last Dental Xray Date: _____

Current Physician: _____ Current Physician City and State: _____

Please list **ALL medications** you are currently taking along with dosages: _____

Please list **ALL allergies**: Aspirin ○ Codeine ○ Latex ○ Penicillin ○ Sulfa ○ Other ○ _____

TURN OVER

Mark any of the following **dental history** that applies:

	Y	N		Y	N
Bad breath	○	○	Lip or cheek biting	○	○
Bleeding gums	○	○	Loose teeth or broken fillings	○	○
Blisters on lips/mouth	○	○	Mouth breathing	○	○
Burning sensation on tongue	○	○	Orthodontic treatment	○	○
Chew on one side of mouth	○	○	Pain around ear	○	○
Clicking or popping jaw	○	○	Periodontal treatment	○	○
Dry mouth	○	○	Sensitivity to cold	○	○
Fingernail biting	○	○	Sensitivity to heat	○	○
Food collection between the teeth	○	○	Sensitivity to sweets	○	○
Foreign objects in mouth	○	○	Sensitivity when biting	○	○
Grinding teeth	○	○	Smoking	○	○
Gums swollen or tender	○	○	Sores or growths in mouth	○	○
Jaw pain or tiredness	○	○			

Mark any of the following **health history** that applies:

	Y	N		Y	N		Y	N
AIDS/HIV	○	○	Epilepsy	○	○	Respiratory Disease	○	○
Anemia	○	○	Fainting or Dizziness	○	○	Rheumatic Fever	○	○
Arthritis, Rheumatism	○	○	Glaucoma	○	○	Scarlet Fever	○	○
Artificial Heart Valves	○	○	Headaches	○	○	Shortness of Breath	○	○
Artificial Joints	○	○	Heart Murmur	○	○	Sinus Trouble	○	○
Asthma	○	○	Heart Problems	○	○	Skin Rash	○	○
Back Problems	○	○	Hepatitis: Type _____	○	○	Special Diet	○	○
Bleeding Issues	○	○	Herpes	○	○	Stroke	○	○
Blood Disease	○	○	High Blood Pressure	○	○	Swollen Feet or Ankles	○	○
Cancer	○	○	Jaundice	○	○	Swollen Neck Glands	○	○
Chemical Dependency	○	○	Jaw Pain	○	○	Thyroid Problems	○	○
Chemotherapy	○	○	Kidney Disease	○	○	Tonsillitis	○	○
Circulatory Problems	○	○	Liver Disease	○	○	Tuberculosis	○	○
Congenital Heart Lesions	○	○	Low Blood Pressure	○	○	Tumor or Growth	○	○
Contact Lenses	○	○	Mitral Valve Prolapse	○	○	Ulcer	○	○
Cortisone Treatments	○	○	Nervous Problems	○	○	Venereal Disease	○	○
Cough: Persistent, Bloody	○	○	Pacemaker	○	○	Weight Loss, Unexplained	○	○
Diabetes	○	○	Psychiatric Care	○	○	Other: _____		
Emphysema	○	○	Radiation Treatment	○	○	_____		

Women: Pregnant ○ Due Date: _____ Nursing ○ Birth Control Pills ○

NEXT PAGE

PRIOR TO CONSENT FORM

You, the patient, have the right to accept or reject dental treatment recommended by this dental office. Prior to consenting to treatment, you should carefully consider the anticipated benefits, commonly known risks of the recommended procedures, alternative treatments, or the option of no treatment. You have the right to ask questions, seek a second opionion, or see a specialist.

Optional Procedure Treatments and Untreated Results

- **Composite Restorations** Optional Treatments: Extraction / Crown
  Untreated: decay will continue to grow eventually causing abcesses and deterioration of the tooth.
- **Scaling & Root Planing** Optional Treatments: See a Periodontist
  Untreated: periodontal pockets will continue to grow causing extensive bone loss.
- **Tooth Extraction** Optional Treatments: No other option
  Untreated: decay will continue to grow eventually causing abscesses and deteroration of the tooth.
- **Endodontics** Optional Treatments: Extraction
  Untreated: abscess remains, infection grows, eventually tooth needs extracted.
- **Prosthodontics** (Crowns, Bridges, Dentures) Optional Treatments: Composite Filling / Implant / Extraction
  Untreated: decay will continue to grow eventially causing abscesses and deterioration of the tooth.
- **Implants** Optional Treatments: Bridge / Crown / Partial / Denture
  Untreated: missing teeth cause shifting and dropping which distort a proper bite.
- **Cosmetic Dentistry** Optional Treatments: N/A
- **Routine Cleanings, Exams, and X-rays** Optional Treatments: N/A
  Untreated: decay and carries go undetected which cause bacteria to grow.

It is very important you provide us with accurate information before, during, and after treatment. It is equally important that you dilligently follow your dentist's advice, recommencdations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointmetns. If you fail to follow these guidelines, you increase the chances of a poor outcome.

No guarantees will be made concerning your recovery or results of the treatments rendered to you.

AUTHORIZATION SIGNATURE:

I acknowledge that I was given (or offered) a copy of this "Prior To Consent Form" for my records. I understand I may ask questions, seek second opinions, and/or seek a specialist before any treatment.

Signature: **Date:**

Patient, Parent, Guardian, or Personal Representative (CIRCLE ONE)

Possible Risks and Complications (not an exhaustive list):

- Bone loss around an implant(s) and/or adjacent teeth, which may result in loss of implant(s) and/or adjacent teeth which may necessitate bone grafting.
- Breakage or dislodgement in buildup failure of restorative material.
- Breakage. Teeth are subject to the possibility of chipping or breakage. There are many factors that may contribute to this possibility including mastication of excessively hard materials, changes in the occlusal forces exerted, traumatic blows to the mouth, etc. Many times, unobservable cracks may develop in crowns from the aforementioned causes, but may actually break when chewing soft foods, or possibly for no evident reason. Seldom does breakage or chipping occur due to defective construction or materials. If this may be the reason, the breakage should occur soon after placement.
- Bruising and/or swelling, delayed healing, restricted mouth opening for several days or weeks.
- Changes in how long teeth appear (due to re-contouring).
- Changes in the shade of the composite restoration over time as a result of the oral environment.
- Changes in speech (usually temporary).
- Changes to bite/position of the temporomandibular joint which may require further treatment or adjustment.
- Cracking or fracturing of the root or crown of the tooth.
- Crown or bridge abutment teeth may require root canal treatment.
- Damage to adjacent teeth or tooth restoration.
- Dark spaces between teeth where there is no longer any gum tissue.
- Delayed healing, including but not limited to, dry socket, necessitating post-operative care.
- Discoloration and appearance changes of the gum tissue or unsatisfactory cosmetic result.
- Drug reactions and side effects. As a result of the injection or use of anesthesia, at times there may be swelling, jaw muscle tenderness or even resultant numbness of the tongue, lips, teeth, jaws and/or facial tissues, which is typically temporary, but in rare instances, may be permanent.
- Esthetics or appearance. Patients will be given the opportunity to observe the appearance of crowns, bridges, dentures, and/or partials in their mouth prior to final cementation. This satisfaction will be acknowledged verbally by the patient and noted in that patient's chart and is binding.
- Future bone or tooth loss.
- Gum tissues may shrink or recede. This change may make some pervious dental restorations (i.e., crowns, fillings) more noticeable and the restorations may need to be replaced for cosmetic purposes.
- Inability to exactly match tooth coloration.
- Inability to negotiate canals due to prior treatment or calcification.
- Inability to place the implant due to the local anatomy or implant failure.
- Increased mobility of teeth.
- Increased spacing between teeth due to removal of hard deposits.
- Infection.
- Instrument breakage in the root canal.
- Irreparable damage to the existing crown or restoration.
- Jaw fracture.
- Loss of bone or tissue graft.
- Longevity of dental work. There are many variables that determine "how long" dental work can be expected to last. General health, maintenance of good oral hygiene, regular dental checkups, diet, etc., can affect longevity. Because of this, no guarantees can be made or assumed.
- Necessity for a more extensive restoration, such as a crown, than originally diagnosed, due to additional decay or unsupported tooth structure found during preparation.
- Necessity for root canal therapy due to injury of pulp tissue.
- Nerve injury resulting in temporary or permanent numbness, itching, burning or tingling of the lip, chin, tongue or teeth.
- Pain from treatment.
- Post-treatment bleeding, oozing, and infection.
- Possible involvement of the nerves of the lower jaw resulting in temporary or permanent tingling of the lower lip, chin, tongue, or surrounding structures.
- Possible involvement of the sinus during the removal of the upper posterior teeth, which may require additional treatment or surgical repair at a later date.
- Reduction of tooth structure. In order to replace decayed or otherwise traumatized teeth it is necessary to modify the existing tooth or teeth so that crowns and/or bridges may be placed upon them. Tooth preparation will be done as conservatively as possible.
- Revealing of recessed gums.
- Root tips may break during the oral surgery process. These root tips may be left in the bone to avoid more aggressive surgery. However, this more aggressive surgery may be needed and you may be referred out for this procedure.
- Sensitivity of teeth. Often, after the preparation of teeth for the reception of crowns or bridges or a whitening treatment, the teeth may exhibit sensitivity. It may be mild to severe. This sensitivity may last only for a short period of time or may last for much longer periods.
- Swelling.
- Tooth may require root canal treatment. There is the possibility that the teeth after being treated may develop a condition known as pulpits or pulpal degeneration. Usually, this cannot be predetermined. The tooth or teeth may have been traumatized from an accident, deep decay, extensive preparation, or other causes. In this case, it is often necessary to do root canal treatments in these teeth. Should teeth remain appreciably sensitive for a long period of time following crowning, it may be necessary to attempt root canal treatment to them. Infrequently, the tooth (teeth) may abscess or otherwise not heal completely. In this event, periapical surgery or even extraction may be necessitated.
- Uncomfortable or strange feelings. This is typically temporary. In limited situations, muscle soreness or tenderness of the jaw may persist following placement of a prosthesis. This may occur because of the differences between natural teeth and the artificial replacements. Normally, a patient will become accustomed to this feeling in time.
- Unsatisfactory aesthetics or appearance.
- Unsatisfactory longevity of crowns and/or bridge.

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Paperwork effective 6/1/2023. This is a legal 6 page document. By signing you agree and understand everything noted.

A copy of this is avaialabe, anytime, upon request.

SIGNATURE PAGE:

●I acknowledge that all information is accurate and understand that falsifying any personal information on this form is fraud and can result in fees, fines, jail time, and being released from Dr. Hurley's care.

●I acknowledge that Dr. Hurley's office may share my information with other health care facilities, insurance companies, and collection agencies to obtain or share health care issues, to obtain payment, and to determine insurance benefits.

●There is a $75.00 charge for **ALL** appointments scheduled and **NOT** canceled at least 24 hours in advance. Cancellations on the same day as the scheduled appointment will be treated as a no show with **NO** exceptions. I acknowledge I will be charged for any appointments **NOT** canceled at least 24 hours in advance and that my insurance company, if any, will **NOT** cover this fee.

●I acknowledge that **ALL** co-payments and deductibles are due ***at the time of service***. Payments can be in the form of check, cash, debit card, or major credit card.

●I acknowledge that Dr. Hurley's office does their best to keep current with all insurance companies and each individual policy, however, **it is MY responsibility to know my insurance plan**. Dr. Hurley's office will only be **ESTIMATING** what my insurance company will cover.

●I acknowledge that once my insurance company has been billed any remaining balance will be **MY** responsibility to pay. Due to privacy laws, if I have any questions concerning my final balance, I must discuss them with my insurance provider.

●I acknowledge that if I am concerned about what my insurance might cover I can request from Dr. Hurley's Office a pre-determination **PRIOR** to the service being done. This process will take approximately 2 - 4 weeks.

●I acknowledge that any balance due after 30 days may be sent to Dr. Hurley's collection agency adding fees, fines, reporting to credit bureau, and a possible legal suit.

Signature: **Date:**

_____ _____

Patient, Parent, Guardian, or Personal Representative

_____

Relation to patient:

PLEASE TURN OVER AND COMPLETE PRIVACY PRACTICES FORM

TURN OVER

HIPPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OR PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

X _____ X _____

Please print name of Patient | Signature of Patient/Guardian/Parent

_____ _____

Legal Representative/Guardian | Relationship of Legal Representative/Guardian

Your comments regarding Acknowledgements or Consents: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIRD OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone ☐ Work Phone Confirmation
☐ Home Phone Confirmation ☐ Email Confirmation ☐ Any of the Above

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone ☐ Work Phone Confirmation
☐ Home Phone Confirmation ☐ Email Confirmation ☐ Any of the Above

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ Any of the Above ☐ Email
☐ Text Message ☐ None of the Above (opt out)

In Signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

o It was emergency treatment o The patient refused to sign o Other (please describe)

o I could not communicate with the patient o The patient was unable to sign because

Signature of Privacy Officer _____