ROBERT B. HURLEY, D.D.S.

"The Gentle Dentist"

118 S. Greenville West Drive
Greenville, MI 48838
616-754-9195

5500 Northland Drive
Grand Rapids, MI 49525
616-364-9451

drhurley@att.net
hurleydentistry.com

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: ____________________
Relationship to Patient: ____________________

Home Phone: ____________________
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 ○ __________

____

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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 ○

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 $65.00 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, major credit card, or through our payment plan company Care Credit.

●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 90 days will 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:

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.

____________________ ____________________

Please print name of Patient — Please sign for Parent/Guardian of Patient

____________________ ____________________

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 APOINTMENTS, 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 AUGHORIZE **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 ____________________

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