Patient Name

MEDICAL HISTORY

Medical Alert	BP

1. Have you been under the care of a Medical Doctor during the past 2 years? Yes No
   If Yes, for what? ______________________________
   Physician's Name ______________________ Phone__________ Fax __________
   Address ______________________ City__________ State______ Zip__________
2. Have you ever taken any medication or drugs during the past 2 years? ______________ Yes No
3. Are you taking any medications, drugs or pills now? (i.e. Aspirin) ______________ Yes No
   If Yes, please list name and dosage ______________________________
   ____
   ____
   ____
4. Have you ever had an allergic or adverse reaction to any medication or substance?______________ Yes No
   If Yes, please list: ______________________________
5. Have you been a patient in a hospital during the past 5 years? ______________ Yes No
6. Indicate which of the following you have had, or have at present. Circle Yes or No to each item.

Heart (Surgery, Disease, Attack)_____	Yes	No	Glaucoma_____________	Yes	No	Hepatitis A, B or C_______	Yes	No
Chest pain ____________________	Yes	No	Contact Lenses________	Yes	No	Venereal Disease_______	Yes	No
Congenital Heart Disease _________	Yes	No	Emphysema __________	Yes	No	A.I.D.S.________________	Yes	No
High Blood Pressure_______________	Yes	No	Chronic Cough_________	Yes	No	H.I.V. Positive___________	Yes	No
Artificial Heart Valve_______________	Yes	No	Tuberculosis___________	Yes	No	Sickle Cell Disease_______	Yes	No
Heart pacemaker_________________	Yes	No	Asthma_______________	Yes	No	Bruise Easily ___________	Yes	No
Arthritis/ Rheumatism______________	Yes	No	Hay Fever_____________	Yes	No	Liver Disease___________	Yes	No
Cortisone Medicine________________	Yes	No	Latex Sensitivity________	Yes	No	Yellow Jaundice_________	Yes	No
Swollen Ankles___________________	Yes	No	Allergies or Hives_______	Yes	No	Neurological Disorders___	Yes	No
Stroke__________________________	Yes	No	Sinus Trouble__________	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)____________	Yes	No	Radiation Therapy_______	Yes	No	Fainting or Dizzy Spells___	Yes	No
Artificial Joints (hip, knee, etc)_______	Yes	No	Chemotherapy__________	Yes	No	Nervous/ Anxious_______	Yes	No
Kidney Trouble __________________	Yes	No	Tumor________________	Yes	No	Psychiatric/Psychological		
Ulcers _________________________	Yes	No	Cold Sores/Fever Blisters	Yes	No	Care_________________	Yes	No
Diabetes _______________________	Yes	No	Blood Transfusion_______	Yes	No			
Thyroid Problems ________________	Yes	No	Hemophilia __________	Yes	No			

7. Do you use more than 2 pillows to sleep?______________________________ Yes No
8. Have you lost or gained more than 10 pounds in the past year?______________________________ Yes No
9. Do you have or have you had any disease, condition, or problem not listed above?______________________________ Yes No
   If yes, please list______________________________
10. **Women.** Are you **pregnant?** Yes____ Months. No **Nursing?** Yes No **Taking Birth Control Pills**? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the periodontist of any change in my health or medications.

______________________________ ______________________________

Signature of Patient, Parent or Guardian Date **Craig Dorion, DDS, MPH Date**

Dr Dorion's Comments:______________________________

____

____

Patient Information

Date____________________

Patient Name: ____ . M . F . Married . Single . Child . Other
Last First MI

Social Security ________________ Birth Date__________ E-Mail________________________________

Phone (Home): ______________ (Cell):_________________(Work): __________________ Ext:_______

Address: ____
Street City State Zip Code

Employer Name:____ Occupation: ____________

Address:____
Street City State Zip Code

. Spouse or . Responsible Party Information (If different than above)

Name: ____. M . F . Married . Single . Child . Other
Last First M

Social Security ________________ Birth Date____________ Phone (Home)______________(Cell):______________

Address:____
Street City State Zip Code

Employer Name: ______________________________Phone #________________Occupation:__________________

Dental Insurance Information

DENTAL Primary Insurance: Patient's relationship to insured: . Self . Spouse . Child . Other________________

Name of Insured: ____Birth Date: __________
Last First MI

Insured's Employer Name:____ Member ID #: ________________

Address____
Street City State Zip Code

Insurance Company Name:_________________________________Phone______________ Group #:______________

Address ____
Street City State Zip Code

DENTAL Secondary or MEDICAL Insurance: Patient's relationship to insured: . Self . Spouse . Child . Other__________

Name of Insured: ____ Birth Date: _________
Last First MI

Insured's Employer Name:____ Member ID #: ________________

Address____
Street City State Zip Code

Insurance Company Name:________________________________ Phone # ______________ Group #:______________

Address

Street City State Zip Code

Referral Information

Name of person or office referring you to our practice: ____

Consent for Services

As a condition of your treatment by this office, payment must be made at the time the services are rendered, unless financial arrangements have been made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.
All emergency dental services, or any dental services performed without previous financial arrangements, must be paid at the time services are performed.
Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms and/or assist the patient in obtaining reimbursement from the insurance company. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

Appointments scheduled in our office are times reserved just for you. We trust no changes will be necessary. If you find it necessary to change your appointment time, please notify us at least 72 hours in advance so that the time can be given to another patient and to avoid a broken appointment charge of $ 50.00 to $ 250.00 depending on the type of appointment.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient's examination.
In consideration for the professional services rendered to me, or at my request, by Dr. Craig Dorion, I agree to pay the fees for services to Dr. Craig Dorion, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be granted.
I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
I certify that I have read and understand the above conditions of treatment and agree to their content.
I certify that I have completed this form to the best of my knowledge and I will not hold my dentist or any other member of her staff responsible for any errors or omissions I may have made herein.

____

Signature of patient, parent or guardian Relationship to Patient Date

.

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
****You May Refuse to Sign This Acknowledgement*****

I, ____, have received a copy of this office's Notice of Privacy Practices.
Print Name

I agree to have Dr. Craig Dorion, or any member of his dental team, share my private and protected health information (PHI) with: My other health care providers and/or insurance company ________________________ ☐ YES ☐ NO

My spouse (name)____ ☐ YES ☐ NO

Other family members (names)____ ☐ YES ☐ NO

____

Signature of **patient**, parent or guardian Relationship to Patient Date

____

Signature of **Insured** person Relationship to Patient Date

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify ____

***Patient's Name*______________________________**

FINANCIAL POLICY

Thank you for choosing NC Periodontics and Implant Center as your periodontal healthcare provider. We are committed to your treatment's success.

Payments: Please understand that payment of your bill is considered part of your treatment.

Payment is expected at the time of service. We accept cash, check, *Visa, MasterCard, Discover, American Express, CitiHealthCard, CareCredit and ChaseHealth Advance.* You can apply for these financing options in our office. Our staff wil be happy to answer any questions you may have.
There will be a **$25.00** handling charge for any **returned checks**.

In the event that your balance remains unpaid 60 days following treatment, a finance charge will be imposed to your account. After 90 days your account will be considered in default and at that time your entire balance shall become immediately due and payable, including all attorney and collection fees and charges. **A $35.00 collection fee** will be charged to your account if it is placed with an outside collection agency. Any patient with unpaid balances that have been placed in collections will **not** receive treatment, except for an emergency situation, unless the balance is paid in full.

Insurance: Your insurance policy is a contract between you, your employer and your insurance company, designed specifically according to your employers needs. **The treatment diagnosed by Dr. Dorion is considered necessary regardless of your insurance benefits.**

As a courtesy, our staff will work very hard to ensure your paperwork is submitted accurately and promptly, to assist you in receiving the maximum dental benefits that your plan allows. They will either mail a check to you, or send it to our office. We cannot guarantee payment from your insurance company. In addition, we are unable to enter into a dispute with them over your claim. This is your responsibility and obligation. **If you have not heard from them after 30 days of submission, please call your insurance company to find out the status of your claim.** We will assist you in any way possible to

see next page

obtain the payment due to you. If you have an outstanding balance with us and receive the payment from your insurance company, it is your responsibility to immediately send us the payment to clear your account. It is also your responsibility to inform us of any changes to your insurance information. If you have already paid for your dental services and a check is issued to us, we will reimburse you.

Appointments: **An appointment written in our schedule with your name on it is a bond of trust that we will be here to serve you and you will be present for that appointment.** When you reserve an appointment we set aside time for you, individually, customized to your needs, therefore, we expect you to keep it.

This reservation is only made with your approval, and is considered confirmed and set whether or not you receive a reminder e-mail, call or postcard. On the rare occasion that we might run late, it is always due to attending to unanticipated needs of other patients, just as your unanticipated needs might need attention. We cannot maintain our level of excellent care, which requires behind the scenes planning and preparation, with cancellations, broken appointments and short notice changes. We require, **at least, 2 business days** notification for any changes to your appointment. We do not accept changes to an appointment left in our answering service; please call the office to personally speak with us.

Broken appointments also deny other patients, like you, of needed care time.

On the rare occasion that we might find it necessary to reschedule your appointment, our commitment to you is to try to reach you as soon as we know, or at least 2 business days in advance.

We prepare individually for each patient and procedure, we assume the costs of room, materials and staff, for this reason, we will charge for any appointment broken or cancelled with short notice, as follows:

Hygiene and Exams (including New Patients' and Periodic Exams)**: $ 50.00**

Surgical appointments: up to $250.00 per scheduled hour.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE FINANCIAL POLICY STATED ABOVE.

____

Patient's Signature Date

Craig Dorion, D.D.S., M.S. P.A

NOTICE OF PRIVACY PRACTICES

**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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/14/03), and will remain in effect until we replace it. 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

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 your health information to obtain payment for services we provide to you.

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.

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 your 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. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

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, but only if you agree that we may do so.

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 our 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 without your written authorization.

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 correctional institution or law enforcement official having lawful custody of protected health information of 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. If you request copies, we will charge you $0.50 for each page, $10.00 per hour 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 a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before 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.

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).

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.

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

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

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 also may 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 us or with the U.S. Department of Health and Human Services.

Contact Officer: Barbara Holahan

Telephone: 919 967 5099 Fax: 919 932 6098

E-mail: info@drabron.com

Address: 900 Martin Luther King Jr. Blvd. (Historic Airport Road) Suite B Chapel Hill, N.C. 27514-2601