DORION & ASSOCIATES
Craig Dorion, DDS, MPH

Patient Name:	Date of Birth:

Medical Alert(s):	B/P	Heart Rate

1. Have you been under the care of a doctor in the past 2 years? **Yes** **No**

If yes, please specify: _____

Physician's Name: _____

Phone Number: _____ City/State: _____

2. Are you taking or have you taken any prescription or over-the-counter medicines in the past two-years? **Yes** **No**
(Including vitamins, natural or herbal/dietary supplements) If yes, please give name and type: _____

3. Are you allergic or have any reaction to any medication/substance? **Yes** **No**

If yes, please specify: _____

4. Have you been a patient in a hospital in the past 5 years? **Yes** **No**

If yes, please specify: _____

5. Do you use more than 2 pillows to sleep? **Yes** **No**

6. Have you gained or loss more than 10 pounds in the past year? **Yes** **No**

7. **Women only:** **A.)** Are you pregnant or recently been pregnant? **Yes** **No**

If yes, how far along are you? _____**Weeks**

B.) Birth Control Use (What type)? **Yes** **No**

C.) Currently Nursing **Yes** **No**

8. Any cardiac/heart condition such as:

Chest pain	**Yes**	**No**
Congestive heart failure	**Yes**	**No**
High or low blood pressure	**Yes**	**No**
Heart valve issues	**Yes**	**No**
Heart surgery	**Yes**	**No**
Pacemaker	**Yes**	**No**

If YES to any of the above, please see S*upplemental Cardiac form.*

9. Do you have or have you ever had the following. Circle **YES** or **NO** to each item that applies to your medical history:

Endocrine:			***GI:***			***Respiratory:***		
Adrenal deficit	Yes	No	GERD	Yes	No	Asthma	Yes	No
Diabetes Type 1/ 2	Yes	No	Stomach Ulcers	Yes	No	Chronic Cough	Yes	No
Most recent A1C	_____		Alcohol use	Yes	No	COPD	Yes	No
Hepatitis A, B, C	Yes	No	If so, how much	_____		Emphysema	Yes	No
Liver Disease	Yes	No	Tobacco use	Yes	No	Sleep Apnea	Yes	No
Thyroid Issues	Yes	No	If so, how much	_____		Tuberculosis	Yes	No
Pancreatitis	Yes	No						

Orthopedic:			***Neurological:***			***Hematology:***		
Artificial Joint(s)	Yes	No	Anxious	Yes	No	AIDs/HIV	Yes	No
Osteoarthritis	Yes	No	Disorders	Yes	No	Bruise (easily)	Yes	No
Rheumatoid Arhtirits	Yes	No	Epilepsy	Yes	No	Hemophilia	Yes	No
Latex Sensitivity	Yes	No	Faint/Dizziness	Yes	No	Sickle Cell	Yes	No
			Seizures	Yes	No	Ulcers	Yes	No
			Stroke	Yes	No			

Oncology:			***Other:***		
Cancer	Yes	No	Allergies/Hives	Yes	No
Chemotherapy	Yes	No	Hearing Aid(s)	Yes	No
Radiation	Yes	No	Cochlear Implant	Yes	No
Bone Marrow Transplant	Yes	No	Tumors	Yes	No
			Organ Transplant	Yes	No

10. Any current or history of use with Bisphosphonates? (Boniva/Fosamax/Actonel/IV) **Yes** **No**

If yes, for how long? **_____ Months/Years**

11. Any medical disease/condition not listed? _____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner.
I have answered all the questions to the best of my knowledge.
Should further information be needed, you have my permission to ask the respective healthcare 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/Guardian **Print Name** **Date** **Signature of Dentist/Hygienist** **Print Name** **Date**

Doctor Comments: _____

_____

_____

DORION & ASSOCIATES
Craig Dorion, DDS, MPH

PATIENT INFORMATION

First name:	Middle:	Last:
Birth date:	Email address:	
Marital status:	What are your pronouns? (This helps us understand the best way to address you).: ☐ She/her ☐ He/him ☐ They/them ☐ I prefer not to say ☐ Other	

Address Street:	Apt #:	City:	State:	Zip Code:

SSN:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Referred by (Please choose one or more option): ☐ Doctor's name:

☐ I was a previous patient here, ☐ Insurance Plan, ☐ Internet, ☐ Location, ☐ Family, ☐ Friend, Name:

Spouse's first name:	Middle:	Last:	SSN:
Occupation:	Employer:		Cell phone no.:

INSURANCE INFORMATION

(Please give your insurance card to the front desk coordinator.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	☐ Yes ☐ No	Is this patient covered by insurance?	☐ Yes ☐ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Name of Primary Insurance:

Subscriber's name:	Subscriber's SSN or ID:	Birth date:	Policy no.:	Phone no.:

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Policy no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

INSURANCE & CONSENT

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the doctor. I understand that I am financially responsible for any balance. I also authorize Dorion & Associates or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

DORION & ASSOCIATES
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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 reserved for you. We trust no changes will be necessary, but if an emergency arises and it is necessary to make a change to your scheduled appointment, please notify us at least two (2) business days in advance so your reserved appointment time can be given to another patient.

I understand that the fee estimate listed for any dental care in this office can only be extended for a period of six months from the date of my examination.

In consideration for the professional services rendered to me by Dorion & Associates, I agree to pay the fees for services to Dorion & Associates 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 work to discuss matters related to this form. I certify that I have read and understand the above conditions.

I certify that I have completed this form to the best of my knowledge and I will not hold my treating dental provider or any other member of Dorion & Associates responsible for any errors or omissions I may have made herein.

_____

Signature of patient, parent or guardian Relationship to Patient Date

DORION & ASSOCIATES
Craig Dorion, DDS, MPH

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 authorize federal official's 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 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. 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: Taylor Marianakis
Telephone: 919-967-5099
E-mail: info@ncimplantcenter.com
Fax: 877-260-7476
Address: 920 Martin Luther King Jr. Blvd. Chapel Hill, NC 27514

DORION & ASSOCIATES
Craig Dorion, DDS, MPH

FINANCIAL POLICY

Thank you for choosing Dorion & Associates as your dental provider. We are committed to providing the best treatment possible to help you achieve your dental health goals.

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, Care Credit and Lending Club.* You can apply for Care Credit and Lending Club financing options in our office. Our staff will 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 employer's needs. **The treatment diagnosed by the doctors at Dorion & Associates 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. 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 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.

see next page

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 Appointments and Exams (including new patient and periodic exams)**: $ 50.00**

Surgical appointments: full amount of 20% surgical deposit *or* 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***

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

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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 _____

DORION & ASSOCIATES
Craig Dorion, DDS, MPH

Authorization for Release of Information - Compound Release

Name of Patient: _____ Date of Birth:_____

Dorion & Associates is authorized to release protected health information about the above-named patient in the following manner and to identified persons.

Entity to Receive Information:
Check each person/entity that you approve to receive information.

□ Voicemail

□ Spouse (provide name and phone number)
_____

□ Parent (provide name and phone number)
_____

□ Email (provide email address)
_____

Description of Information to be Released:
Check each that can be given to person/entity the left.

□ Results of lab tests/x-rays

□ Financial
□ Medical

□ Financial
□ Medical

□ Financial
□ Medical
□ Breach notification

□ **For email communication I understand that if email is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communication.**

Patient Rights:
- I have the right to revoke the authorization at any time.
- I may Inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information read or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

_____ Date:_____
Signature of Patient or Personal Representative*
*Description of Personal Representative's Authority (attach necessary documentation)