Western Carolina Family Dentistry
Matthew Beauchemin, DMD
505 Realty Street SW
Lenoir, NC 28645

Date_____________ Home Phone___________________________ Cell Phone ____________________________

Name____
Last First MI

Date Of Birth________/_________/________ SSN: _________--_________--_________

Address____

City________________________________ State_____________ Zip________________

Primary Insurance

Who is responsible for this account?_____________________ Relationship to Patient?__________________________

Date Of Birth________/_________/________ SSN: _________--_________--_________

Insurance Co. ____ Group#____________________________

Employer: ____________________________________ Medicaid/Medicare Member ID #_______________________

If the patient has additional insurance, please notify someone at the front desk
WHEN FILING INSURANCE, THE SOCIAL SECURITY NUMBER & DATE OF BIRTH OF THE POLICYHOLDER ARE REQUIRED

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and assign directly to Dr. Beauchemin all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company/companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature/Relationship: ____ Date:______/_____/_______

Emergency Contact

Name ____ Relationship _______________________

Home Phone __________________________ Cell Phone _________________________

Dental History

Reason for today's visit ____

Former Dentist ____ City/State _____________________________

Date of last dental visit ____________________________ Date of last dental x-rays __________________________

How often do you floss? _________________ How often do you brush? ____________________

Health History

Physician's Name ____ Date of Last Visit ___________________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These Include Combinations of Ionamin, Adipex, Fastin (brand names of Phentermine, Pondimin (fenfluramine) and Redux (dexfenfluramine) YES or NO

Have you ever taken any of the group of drugs collectively referred to as "bisphosphonates"? These include Fosamax, Zometa, Aredia, Actonel, and Skelid. ____Yes ____No

Do you have a history of bacterial endocarditis? ____Yes _____No *If yes when were you diagnosed? _______________

Please mark "X" to indicate if you have or have had any of the following:

AIDS/HIV		Excessive Bleeding		Lung Disease	
Alzheimer's Disease		Excessive Thirst		Mitral Valve Prolapse	
Anemia		Fainting/Dizziness		Osteoporosis	
Arthritis		Frequent Cough		Psychiatric Care	
Artificial Heart Valves		Frequent Headaches		Radiation Treatments	
Artificial Joints		Glaucoma		Rheumatic Fever	
Asthma		Genital Herpes		Rheumatism	
Blood Disease		Heart Attack		Scarlet Fever	
Blood Transfusion		Heart Murmur		Seizures	
Breathing Problems		Heart Pacemaker		Sinus trouble	
Cancer		Heart Trouble		Skin Rash or Hives	
Chemotherpy		Hemophilia		Special Diet	
Circulatory Problems		Hepatitis Type A		Stroke	
Congenital Heart Disorder		Hepatitis Type B		Swelling of Limbs	
Convulsions		Hepatitis Type C		Swollen Neck Glands	
Cortisone Treatments		Herpes		Thyroid Disease	
Diabetes		High blood pressure		Tuberculosis	
Drug Addiction		Hypoglycemia		Tumor or growth	
Dialysis		Kidney Disease		Ulcers	
Emphysema		Liver Disease		High Cholesterol	
Epilepsy		Low Blood Pressure		Yellow Jaundice	

Do you have any other medical history or surgeries not listed above?

Please mark (X) to indicate if you have had any of the following

_____Bad Breath
_____Bleeding Gums
_____Blisters on lips or mouth
_____Burning sensation on tongue
_____Cigarette, pipe, or cigar smoking
_____Dry mouth
_____Fingernail biting
_____Food collection between teeth
_____Grinding teeth
_____Gums swollen or tender
_____Jaw pain or tenderness
_____Lip or cheek
_____Loose teeth or broken filling
_____Mouth breathing
_____Mouth pain, brushing
_____Orthodontic treatment
_____Pain around ear
_____Periodontal treatment
_____Sensitivity to cold
_____Sensitivity to sweets
_____Sensitivity to heat
_____Sensitivity when biting
_____Oral sores or growths

Do you wear contact lenses? ___Yes ___No

Women Only:

Are you pregnant? ___Yes ___No Due Date _________ Are you nursing? ___Yes ___No

On Birth Control? ____ Yes ____ No

Allergies
Please mark (X) any of the following to which are allergic:

Aspirin ____ Local Anesthetic ____ Sulfa ____ Azithromycin (Z-Pack) _____ Penicillin ______

Codeine ____ Barbiturates ____ Latex ____ Tramadol ____ Amoxicillin _____

Other (Please Specify): ____

Pharmacy Name ____ Phone: ______________________

Medications (please list all):

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NOTICE OF PRIVACY PRACTICES

Your Privacy is very important to us here at Western Carolina Family Dentistry.
We promise to take every precaution to protect your rights to having your healthcare information secure.

You are entitled to a copy of our Notice of Privacy Practices, which will be located at the reception area.

We also need to ask our patients how they wish to be notified about future appointments at least 48 hours in advance. If we are unable to contact you we leave a message on your voicemail or text message.

Please answer the following so that we may comply with your wishes concerning appointment information.

Western Carolina Family Dentistry may call my home/workplace/cell to confirm future appointments and may leave a message on my voice mail or send a text message.

_______________ Yes _________________ No

By my signature, I acknowledge that I have read the posted Notice of Privacy Practices which describes the uses and disclosures of my health information.

Patient Name: ____

Please print name: ____

Patient/ Guardian Signature: ____

Date: _______________________