**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?

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**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: _____

# Understanding Dental Insurance

## **** ATTENTION: Please Read Carefully! ****

We have prepared this letter to help you better understand the complexities of dental insurance; we realize how confusing it can be. To begin, we would like to correct the common misunderstanding that dental insurance will pay for all your dental care. **It will NOT!**

Please understand: **dental insurance is not designed to pay for all of your dental care.**

Most contracts have yearly limits, treatment limitations and / or various degrees of co-payments. All levels of payment by insurance companies, including allowed fees, usual, customary, and reasonable (UCR) are governed by the premiums paid. They have nothing to do with the actual fee for services rendered. Our fees are based upon a combination of our cost, our time, and our consistent dedication to providing our patients with the highest quality of dental care. Thus, there can be a discrepancy between the amounts covered under your policy's UCR schedule, and the actual cost of the procedure. **The discrepancy is the patient's responsibility.** The dental office has no way to know everyone's exact insurance coverage will be. We can only give an **ESTIMATE** of coverage.

The treatment recommended by our practice is never based on what your insurance company will pay, as your oral health care and accompanying treatment should not be governed by your insurance company contract.

Thus, it should be understood that the **dental insurance contract is between the insurance company and the patient.** If you are unclear as to whether a particular procedure is covered by your carrier, we can submit a pre-estimate for treatment before scheduling.

We hope this information has been helpful. Please take the time to review your insurance policy thoroughly so that you have a better understanding of your coverage.

Date: _____

Patient Name: _____

Patient/Guardian Signature _____