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: _____

NC MEDICAID & NC HEALTH CHOICE
POLICIES AND AGREEMENT

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

Unfortunately, previous patients using Medicaid and/or NC Health Choice have had an extremely high number of broken appointments. The results of those numerous broken appointments have been unnecessary and sometimes painful delays for other patients in need of treatment.

Therefore, the following regulations have been instituted to eliminate broken appointments and to treat motivated patients in a timelier manner. Failure to adhere to ALL of these policies will result in dismissal from this practice.

1. You **MUST** be on time for your appointment. **If you arrive more than 10 minutes late, your appointment will automatically be canceled and it will be marked as a broken appointment. After the 2nd broken appointment, you will be dismissed from the office.**

2. We will attempt to call you up to 2 business days before your scheduled appointment to confirm the appointment. If a message is left on your answering machine or with someone, you must call back to confirm the appointment or we will assume that you are not coming.

3. Any co-pay must be resolved before your appointment. We do not accept checks. We do accept VISA, MasterCard, & Cash Only. Failure to settle any balance and/or failure to have Medicaid or NC Health Choice card will result in cancellation of your appointment as well as dismissal from this practice.

**** ATTENTION ****

If you need to cancel an appointment for any reason, you must give a 48-hour notice or the cancellation will be considered a broken appointment and we will not be able to reschedule you for a future appointment; you will be dismissed. Please feel free to leave a message on our answering machine to cancel or reschedule any appointments, but remember to give at least a 48-hour notice.

FOR NC HEALTH CHOICE RECIPIENTS ANY SERVICES NOT COVERED BY YOUR DENTAL PLAN YOU WILL BE HELD RESPONSIBLE FOR.

Patient Name: _____ Date: _____

Patient/Guardian Signature: _____

ASSIGNMENT OF BENEFITS Western Carolina Family Dentistry 505 Realty St. SW Lenoir, NC 28645