Region Dental
1702 A St
La Porte, IN 46350
219-362-8980
office@regiondentalcare.com

Registration Information

Patient Name: _____ Preferred Name: _____
Last First MI

☐ Married ☐ Single ☐ Child ☐ Other

Social Security #:_____ Birth Date: _____

Phone (Home): _____ (Cell):_____ Work:_____

E-Mail Address:_____ Would you like text/email reminders? ☐ Yes ☐ No

Home Address:_____
Street City State Zip

Employer Name_____

Emergency Contact Name and Phone_____

Appointment Cancellation Policy

We require 24 hours notice for appointment cancellations. Appointment changes & or cancellations without adequate notice may be subject to a fee of up to $50.00, payable by the patient and not the insurance company.

Patient/Guardian Signature_____ Date_____

Insurance Information

Primary Insurance Policy

Name of Policy Holder: _____ Is the Policy Holder a patient? Yes ☐ No

Policy Holder's Date of Birth: _____ Policy Holder's ID#/SS# _____ Group # _____

Policy Holder's Employer: _____ Patient's relationship to the Policy Holder: Self Spouse Child _____

Dental Insurance Company Name: _____ Other _____ Phone #: _____

Secondary Insurance Policy

Name of Policy Holder: _____ Is the Policy Holder a patient? ☐ Yes ☐ No

Policy Holder's Date of Birth: _____ Policy Holder's ID# _____ Group # _____

Policy Holder's Employer: _____ Patient's relationship to the Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Dental Insurance Company Name: _____ Phone #: _____

Please be aware that we collect estimated insurance portions at each visit. Your insurance policy is a contract between you and your insurance company. You are responsible for any unpaid balances, regardless of the original estimate of insurance benefit. As a courtesy to you we will file your claims with your insurance company. Insurance payments are normally received within 30 to 45 days. **Any unpaid balances after 60 days are your responsibility and are due at that time. All deductibles and co-payments are due at the time of service.** We try to answer any questions you may have about your insurance company, however you may need to contact your insurance company for additional information. If your insurance changes, it is your responsibility to provide updated information to our office.

Assignment of Benefit: Please read and sign to have our office file your insurance: I authorize the release of information and understand that I am responsible for all costs of dental treatment. I hereby authorize payment directly to Region Dental of the insurance benefits otherwise payable to me.

X Signature of patient, parent or guardian: _____ Date: _____

Billing Policy, Consent for Treatment and Payment

Payment is expected at time of service. We accept cash, check, Visa, Discover, MasterCard and CareCredit. Returned checks are subject to a $25.00 fee. Aged balances over 60 days, regardless of insurance, are subject to a billing charge of $2.00 per month and/or finance charges of 21.0% A.P.R. Balances not paid within ten days of the due date are subject to a late fee of 5% or $15.00 per service date. A past due balance is any amount owing from a prior visit where an insurance payment has not been received by us within 60 days. If you have a past due balance and wish to receive service, you will be required to pay the past due balance and the new charges at time of service.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:
I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for and by members of my family shown by statements, promptly upon presentation thereof. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing date. In event legal action should become necessary to collect an unpaid balance due for medical services rendered to my family or me I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper. It is agreed that all payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof.

X Signature:_____ **Date:**_____

Acknowledgement of receipt of Notice of Privacy Practices (HIPAA)

You may refuse to sign this acknowledgement.

I, _____ have been offered & or received a copy of this office's Notice of Privacy Practices and consent to the operations it describes. healthcare

Print the Name of the Patient or Personal Representative: _____

X Signature of Patient or Personal Representative: _____ Relationship to Patient:_____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
○ aspirin, ibuprofen, acetaminophen, codeine _____		
○ penicillin _____		
○ erythromycin _____		
○ tetracycline _____		
○ sulfa _____		
○ local anesthetic _____		
○ fluoride _____		
○ chlorhexidine (CHX) _____		
○ iodine _____		
○ metals (nickel, gold, silver, _____)		
○ latex _____		
○ nuts _____		
○ fruit _____		
○ milk _____		
○ red dye _____		
○ other _____		
3. heart problems, or cardiac stent within the last six months _____	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker, implantable defibrillator, or organ transplant _____	☐	☐
7. orthopedic or soft tissue implant (e.g., joint replacement) _____	☐	☐
8. heart murmur, rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (or INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15. breathing problems (e.g., asthma, nasal breathing, stuffy nose, sinus congestion)	☐	☐
16. sleep problems (e.g., sleep apnea, snoring, insomnia, restless sleep, bedwetting)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease or jaundice _____	☐	☐
19. vertigo (e.g., "the room is spinning") _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency or imbalance (e.g., polycystic ovarian syndrome) _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g., gastric reflux, bulimia, anorexia, celiac disease, Crohn's disease, or any inflammatory bowel disease) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g., bisphosphonates) _____	☐	☐
27. arthritis or gout _____	☐	☐
28. autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (e.g., Alzheimer's disease, dementia, prion disease)	☐	☐
34. viral infections (e.g., cold sores) bacterial infections (e.g., Lyme disease)	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type _____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. difficulties with stress management _____	☐	☐
44. psychiatric treatment, antidepressants, mood stabilizing medications	☐	☐
45. concentration problems or ADD/ADHD _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements, vitamins, and/or probiotics _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches or chronic pain _____	☐	☐
53. a smoker, smoked previously or other (e.g., smokeless tobacco, vaping, e-cigarettes, and cannabis) _____	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant or breastfeeding _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist _____ How long have you been a patient? _____ Months / Years

Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____

Date of most recent treatment (other than a cleaning) ____/____/____

I routinely see my dentist every . . . ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]? _____	☐	☐
2. Have you had an unfavorable dental experience? _____	☐	☐
3. Have you ever had complications from past dental treatment? _____	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____	☐	☐
6. Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma? _____	☐	☐
GUM AND BONE	**YES**	**NO**
7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing? _____	☐	☐
8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth? _____	☐	☐
9. Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums? _____	☐	☐
10. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth? _____	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing? _____	☐	☐
13. Have you experienced a burning, painful sensation, or metallic taste in your mouth? _____	☐	☐
TOOTH STRUCTURE	**YES**	**NO**
14. Have you had any cavities within the past 3 years? _____	☐	☐
15. Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food? _____	☐	☐
16. Do you feel or notice any holes (i.e., pitting, craters) on the biting surface of your teeth? _____	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____	☐	☐
18. Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
20. Do you frequently get food caught between any teeth? _____	☐	☐
BITE AND JAW JOINT	**YES**	**NO**
21. Does your jaw joint ever have pain, sounds (clicking, crackling, or popping), or experience limited opening or locking? _____	☐	☐
22. When you bite all of your back teeth together, does it feel like your lower jaw has to move backward, or is being pushed back by your teeth?	☐	☐
23. Do you ever have pain in your facial muscles, or have difficulty chewing gum, raw carrots, nuts, bagels, or other hard, dry foods? _____	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____	☐	☐
26. Are any of your teeth becoming looser or are spaces forming between your teeth? _____	☐	☐
27. Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better? ___	☐	☐
28. Do you usually place your tongue between your teeth, use it to push against them, or bite your cheeks or lips? _____	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
30. Do you clench or grind your teeth together in the daytime / nighttime or ever make them sore? _____	☐	☐
31. Do you have any problems with sleep (i.e., restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? __	☐	☐
32. Have you ever used a bite appliance, Botox, or any medication for clenching, teeth grinding, or jaw discomfort? _____	☐	☐
SMILE CHARACTERISTICS	**YES**	**NO**
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, display)?	☐	☐
34. Have you ever bleached (whitened) your teeth? _____	☐	☐
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____	☐	☐
36. Have you been disappointed with the appearance of previous dental work? _____	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature Date