BLACK HILLS pediatric DENTISTRY

Where Bright Smiles Begin

PATIENT REGISTRATION AND MEDICAL/DENTAL HISTORY

ABOUT YOUR CHILD

Patient's Name:_____ Preferred Name: _____

Date of Birth:_____ ☐ Male ☐ Female

Home Address:_____ Home Phone: _____

City:_____ State:_____ Zip Code: _____

How did you hear about our office?

☐ Friend: _____ ☐ Dr. Referral ☐ Online ☐ Other _____

ADDITIONAL INFORMATION

Preferred Pharmacy Name & Location: _____

PERSON(S) RESPONSIBLE FOR ACCOUNT

*PARENT OR LEGAL GUARDIAN INFORMATION

Name: _____ ☐ Male ☐ Female Date of Birth: _____

Relationship to Patient: ☐ Mom ☐ Dad ☐ Stepmom ☐ Stepdad ☐ Foster Parent ☐ Guardian ☐ Other _____

Mailing Address:_____ Social Security #: _____

City, State, Zip Code: _____ Home Ph: _____

Employer: _____ Work Ph:_____

E-Mail Address:_____ Cell Ph: _____

*PARENT OR LEGAL GUARDIAN INFORMATION

Name: _____ ☐ Male ☐ Female Date of Birth: _____

Relationship to Patient: ☐ Mom ☐ Dad ☐ Stepmom ☐ Stepdad ☐ Foster Parent ☐ Guardian ☐ Other _____

Mailing Address:_____ Social Security #: _____

City, State, Zip Code: _____ Home Ph: _____

Employer: _____ Work Ph:_____

E-Mail Address:_____ Cell Ph: _____

***Signature (Parent or Legal Guardian ONLY):**_____

EMERGENCY INFORMATION

In case of an emergency where neither parent nor legal guardian can be reached, please identify the following information for the next closest relative not living with the parent.

Name: _____ Relation:_____ Home Phone:_____

Address: _____ Cell Phone:_____

MEDICAL HISTORY

Patient's Name _____
(First) (Last)

Date of Birth _____ Wt: _____ Ht: _____

Has your child ever had any of the following conditions?

Yes	No		Yes	No	
☐	☐	Food Allergies? (especially eggs)? _____	☐	☐	Cystic Fibrosis
☐	☐	Allergic to any medications? _____	☐	☐	Tuberculosis
☐	☐	Bad reaction to any medications? _____	☐	☐	Cerebral Palsy
☐	☐	Latex Allergy or Sensitivity? _____	☐	☐	Developmentally Delayed
☐	☐	Eczema / any other skin conditions?	☐	☐	Visually Impaired / Blindness
☐	☐	Is the patient currently taking any medication(s)? If yes, please list: _____	☐	☐	Epilepsy, Seizures or Convulsions
☐	☐	Rheumatic or Scarlet Fever?	☐	☐	Hyperactivity / ADD / ADHD
☐	☐	Heart Condition / Heart Murmur. If "Yes" to either: has your child's doctor recommended antibiotics prior to dental care? _____	☐	☐	Autism
☐	☐	Has your child ever been hospitalized? _____	☐	☐	Psychiatric Care
☐	☐	Has your child ever had surgery? _____	☐	☐	Child Abuse
☐	☐	MRSA (Methicillin-resistant Staphylococcus aureus)	☐	☐	Hearing Impairment
☐	☐	Asthma / Reactive Airway Disease?	☐	☐	Birth Defects
☐	☐	Does your child use a nebulizer? If so, how often? _____	☐	☐	Cleft Palate
☐	☐	Snoring	☐	☐	Kidney Disease or Transplant
☐	☐	Malignant Hyperthermia?	☐	☐	Diabetes
☐	☐	Premature? _____ weeks	☐	☐	Hepatitis or Liver Disease
☐	☐	Immunizations Current?	☐	☐	Anemia / Low Blood Count
			☐	☐	Other Conditions
			☐	☐	Is your child currently under the care of a doctor? If so, why? _____

PLEASE LIST ALL DOCTORS PATIENT HAS SEEN IN THE LAST 2 YEARS (i.e., for Well Baby checks, Sports Physicals, specialists like HEART DOCTOR, PSYCHOLOGIST, etc...)

Type of Doctor_____ Name_____ Office Phone_____

Type of Doctor_____ Name_____ Office Phone_____

Type of Doctor_____ Name_____ Office Phone_____

DENTAL HISTORY

Has your child ever suffered from any of the following conditions?

Yes	No		Yes	No	
☐	☐	Bad Breath/Halitosis	☐	☐	Dental Infection or Abscess
☐	☐	Bleeding Gums	☐	☐	Recent Dental Pain
☐	☐	Stained and Discolored Teeth	☐	☐	Missing or Extra Teeth
☐	☐	Cold Sores or Fever Blisters	☐	☐	Thumb/Finger Sucking
☐	☐	Dry Mouth	☐	☐	Dental Grinding/Clenching

☐ ☐ Do you wish to talk to the doctor privately about any special concerns?

☐ ☐ Has your child experienced any unfavorable reaction from previous medical or dental care? (If yes, please explain):

_____

☐ ☐ Injury or Trauma to Teeth, Mouth or Face (If yes, please explain):

_____

☐ ☐ Does your child receive fluoride supplementation from vitamins, water or tablet/drops?

How do you think your child will act toward the dentist?

☐ Cooperative ☐ Fearful ☐ Defiant ☐ Don't know

Parent/Legal Guardian Signature _____ Date _____

Pediatric Clinic
1211 E. Wells Ave.
Pierre, SD 57501-3962

700 Sheridan Lake Road
Rapid City, SD 57702-2407

Adolescent Clinic
720 Sheridan Lake Road
Rapid City, SD 57702-2407

www.bhpediatricdentistry.com • Phone (605) 341-3068 • Fax (605) 341-5757 • email: info@bhpdentistry.com

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DENTAL INSURANCE INFORMATION

Primary Insurance Co. _____ Ins. Co. Phone: _____

Primary person on Policy? _____ I.D. # _____

Date of Birth _____ Group # _____

Employer _____

Secondary Ins. Co. _____ Ins. Co. Phone: _____

Primary person on Policy? _____ I.D. # _____

Date of Birth _____ Group # _____

Employer _____

MEDICAL / DENTAL RELEASE STATEMENT

I give my consent for the dentists at Black Hills Pediatric Dentistry to do a complete and thorough examination on the patient previously named, including any diagnostic x-rays needed. To the best of my knowledge, the information that I have given is correct and I understand that it will be held in the strictest confidence. Furthermore, I understand that it is my responsibility to inform Black Hills Pediatric Dentistry of any future changes to my child's medical status. As the parent or legal guardian of the previously named patient, I do hereby grant Black Hills Pediatric Dentistry and its staff permission to perform any needed treatment(s). I also understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time of service, unless prior arrangements have been approved. *Initial* _____

REQUIREMENT FOR FILING INSURANCE CLAIMS. To expedite the filing of my dental insurance claims, I do hereby authorize the release of confidential information to my dental insurance agency and understand that I am personally responsible for any balance remaining after the insurance payment has been received. I am also fully responsible if my insurance policy fails to pay, for any reason, within thirty (30) days of treatment. I hereby authorize payment of insurance benefits directly to Black Hills Pediatric Dentistry or the dentist that performs treatment on my child. (*Please Note: Blue Cross/Blue Shield and Dakotacare are handled differently as they only send the benefit checks directly to the policyholder.*)

Parent or Legal Guardian Signature _____ Date _____

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LEGAL CONSENT TO MAKE DECISIONS

Patient(s) Name(s) and Date(s) of Birth: _____

As a convenience, we would like to offer you a chance to provide Black Hills Pediatric Dentistry with a list of individual(s) that may accompany your child to subsequent visits. Listing an individual will provide them with your legal consent to make both treatment and financial decisions on your behalf.

With this list, a family member, step-parent, or good friend would have the authority to accompany your child to the dental appointment and make decisions without the need of any additional written or verbal consent. If not listed, patients must always be present with a parent or legal guardian. Please only provide the names of those individuals that you trust to make such decisions as treatment changes, to make payments, and to discuss medical and financial information.

We, as an HIPAA compliant healthcare facility, will use our best discretion to maintain all personal information and will only provide the individuals listed below with information needed to make a specific decision on your behalf. Information will only be provided on a need-to-know basis and we will not allow these individuals to have or copy your child's dental chart. We simply want to make treating your child in our facility as convenient as possible for you.

Please identify such individuals and initial your decision to allow them to provide consent to make treatment decisions, to make financial arrangements, or both.

CONSENT TO MAKE DECISIONS

Individual's Name	Relationship

As the parent or legal guardian of the patient noted above, I do hereby provide the individuals listed beneath the chart entitled "Consent to Make Decisions", the legal authority to make decisions in my absence. I also understand that these decisions may change or alter previous treatment recommendations or charges that I have already agreed to and that I, as this child's parent or legal guardian, am ultimately responsible for any new charges incurred as a result of treatment decisions made by any individual listed above.

RECORDING POLICY

RECORDING POLICY: ***It is the policy of Black Hills Pediatric Dentistry and Rushmore Ambulatory Surgery Center that photography, videography, or any type of recording during the visit is prohibited to protect the privacy of all of our practitioners, patients, family members and guests, unless both the practitioner and you consent in writing to the videography, photography, or recording. BHPD/RASC strongly encourages all patients, family members and guests to take notes during your visit with us, and/or to request a copy of your visit documentation for your personal records. In signing below, I acknowledge that I have been informed and will abide by BHPD/RASC's policy.***

Parent or Legal Guardian Signature: _____

Printed Name: _____ Date _____

Relationship to Patient: _____

********** FOR OFFICE USE ONLY **********

I attest that the following documents were provided to the parent or legal guardian of the child noted above. All questions have been answered and I have witnessed the signing of these consent statements.

Witness Signature _____ Date _____

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