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	
☐	☐	Anaphylactic Shock/Facial swelling	☐	☐	Immunizations Current
☐	☐	Food Allergies? (especially eggs)	☐	☐	Cystic Fibrosis
		_____	☐	☐	Tuberculosis
☐	☐	Allergic to any medications_____	☐	☐	Cerebral Palsy
☐	☐	Bad reaction to any medications_____	☐	☐	Developmentally delayed
☐	☐	Latex allergy or sensitivity_____	☐	☐	Visually impaired / blindness
☐	☐	Eczema / any other skin conditions_____	☐	☐	Epilepsy, seizures, or convulsions
☐	☐	Is the patient currently taking any medication(s) If yes, please list:_____	☐	☐	Hyperactivity / ADD / ADHD
			☐	☐	Autism
☐	☐	Rheumatic or Scarlet Fever	☐	☐	Psychiatric care
☐	☐	Heart condition / Heart murmur - If "Yes" to either: has your child's doctor recommended antibiotics prior to dental care_____	☐	☐	Child abuse
			☐	☐	Hearing Impairment
			☐	☐	Birth defects
☐	☐	Has your child ever been hospitalized _____	☐	☐	Cleft Palate
☐	☐	Has your child ever had surgery _____	☐	☐	Kidney Disease or transplant
☐	☐	MRSA (Methicillin-resistant staphylococcus aureus)	☐	☐	Diabetes
☐	☐	Asthma / Reactive Airway Disease	☐	☐	Hepatitis or Liver Disease
☐	☐	Does your child use a nebulizer? If so, how often?	☐	☐	Anemia / Low blood count
		_____	☐	☐	Other conditions
☐	☐	Snoring	☐	☐	Is your child currently under the care of a doctor? If so, why?_____
☐	☐	Malignant Hyperthermia			
☐	☐	Premature? How many weeks_____			

PLEASE LIST ALL DOCTORS PATIENT HAS SEEN IN THE LAST 2 YEARS (i.e. 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:_____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's ***Notice of Privacy Practices.*** I agree to accept telephone messages and/or emails regarding my child(ren)'s appointment schedule information.

_____

Please Print **Patient**(s) Name

_____ _____

Parent or Guardian Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____

_____

Dental Insurance Information

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

Subscriber's Name: _____ DoB: _____

SSN: _____ I.D. #: _____

Employer: _____ Group #: _____

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

Subscriber's Name: _____ DoB: _____

SSN: _____ I.D. #: _____

Employer: _____ Group #: _____

Note: Our office does not verify Insurance. Please verify your child's coverage prior to appointment by checking with your Insurance Company.

Medical Insurance Information

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

Subscriber's Name: _____ DoB: _____

SSN: _____ I.D. #: _____

Employer: _____ Group #: _____

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

Subscriber's Name: _____ DoB: _____

SSN: _____ I.D. #: _____

Employer: _____ Group #: _____

Note: Our office does not verify Insurance. Please verify your child's coverage prior to appointment by checking with your Insurance Company.

At BHPD, we are not contracted with all insurance companies. At this time, we are premier provider with Delta Dental and in-network with Medicaid of South Dakota and Wyoming. It is your responsibility to make certain your insurance plan will pay for your visit. Please understand that your insurance benefits are determined by your insurance company and/or your employer. Regardless of what we may calculate your insurance company to pay, it is only an estimate. We must stress that you are responsible for the total treatment fee.

Note: During your child's preventative visits, we usually perform the following services:

- Examine your child's teeth, gums and surrounding tissue.
- Clean your child's teeth
- Apply a fluoride varnish
- Take x-rays as indicated to establish and diagnose your child's oral health (depending on age and need.) Please check with your insurance provider regarding your allowances for these services.

As a reminder, the guarantor of the account is the person who is financially responsible for the amounts due and who signs below. This responsibility is regardless of any insurance participation and irrespective of who may be the main subscriber to the insurance. Black Hills Pediatric Dentistry is unable to get involved in family dynamics, so payment will be the responsibility of the guarantor.

SD/WY MEDICAID PATIENTS: You are responsible for keeping your Medicaid active. If you fail to do so, you will be responsible for the full balance.

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 medical 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 is handled differently as they only send the benefit checks directly to the policy holder.

Parent or Legal Guardian Signature _____ Date _____

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 as well as scheduling and confirming appointments 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 a 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	Phone Number	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 recommenda tions 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 _____