Black Hills Pediatric Dentistry 700 Sheridan Lake Rd. P.O. Box 9427 Rapid City, SD 57709-9427

ABOUT YOUR CHILD



Phone: (605) 341-3068 Fax: 605-341-5757

www.bhpediatricdentisry.com

"Putting your child's dental health on the right track."

PATIENT REGISTRATION AND MEDICAL/DENTAL HISTORY

Welcome to Black Hills Pediatric Dentistry. We would like to welcome you and your child to our dental office. Our primary goal is to make every visit fun and educational. Our practice is based on preventive dental care. We strive to teach good oral care that will enable your child to maintain a beautiful smile for a lifetime!

Patient's Name	Preferred Name				
Date of Birth	Male Female				
Home Address			Home	e Phone	
City		State		Zip Code	
How did you hear about our office	?				
Friend	Dr. Referral	Paper	Yellow Page	es Other	
PERSONS RESPONSIBLE FO	R ACCOUN	IT			
PARENT / LEGAL GUARDIAN INFORM	MATION				
Name:				Date of Birth:	
Mailing Address:				Social Security #:	
City, State, ZIP:				Home Phone:	
Employer:				Work Ph:	
E-Mail Address:				Cell Ph:	
ADDITIONAL PARENT / LEGAL GUAR	<u>DIAN</u> INFORM	ATION			
Name:				Date of Birth:	
Mailing Address:				Social Security #:	
City, State, ZIP:				Home Phone:	
Employer:		1645		Work Ph:	
E-Mail Address:				Cell Ph:	
EMERGENCY INFORMATION	V				

In case of an emergency where neither parent nor legal guardian can be reached, please identify the following

Relation

Home Phone

Cell Phone

information for the next closest relative not living with the parent.

Name

Address

MEDICAL HISTORY

Patient's Name

Has your child ever had any of the following conditions?

Anemia **Hearing Impairments Heart Condition** Kidney Disease or Transplant Rheumatic/Scarlet Fever Hepatitis or Liver Disease Child Abuse Cancer, Malignancies or Leukemia Asthma Infection **Diabetes** Cleft Lip/Palate Epilepsy, Seizures or Convulsions Cerebral Palsy Hyperactivity/ADD Birth Defects Psychiatric Care **Developmentally Delayed** Latex Allergy or Sensitivity **Tuberculosis or Previous Positive Test** Pain in Jaw Joints Autism **Excessive Bleeding** Hemophilia Is Pre-Med necessary due to a heart condition or other medical reason? Is the patient currently taking any medication(s)? (If yes, please list) Is the patient currently under the care of a physician? (If yes, for what?)

PLEASE LIST ANY TREATING DOCTOR (I.E. PEDIATRICIAN)

Type of doctor Name Office Phone:

Is your child allergic or has your child ever had an adverse reaction to a specific medication?

DENTAL HISTORY

(If yes, which?)

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

nas you	i cilia ever surrerea	from any or the f	Showing co	Huluons:			
Yes No		Yes No					
	Bad Breath/Halitosis		Dent	tal Infection or Abscess			
	Bleeding Gums		Rece	ent Dental Pain			
	Stained and Discolored tee	eth	Missing or Extra Teeth				
	Cold Sores or Fever Blister	rs .	Thur	mb/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?							
C	Cooperative	Fearful De	fiant	Dorft Know			

Parent / Legal Guardian Signature

Date