

"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!

ABOUT YOUR CHILD						
Patient's Name	Preferred Name					
Date of Birth	Male Female					
Home Address	Home Phone					
City		Stat	te	Zip Code		
How did you hear about our offic	e?					
Friend	Dr. Referral	Paper	Yellow Page	es Other		
PERSONS RESPONSIBLE F	OR ACCOU	T				
PARENT / LEGAL GUARDIAN INFOR	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 GUARDIAN INFORMATION						
Name:				Date of Birth:		
Mailing Address:				Social Security #:		
City, State, ZIP:				Home Phone:		
Employer:				Work Ph:		
E-Mail Address:				Cell Ph:		
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 <u>not</u> living with the parent.						
Name	1	Relation		Home Phone		
Address				Cell Phone		

#### **MEDICAL HISTORY**

#### Patient's Name

Has your child ever had any of the following conditions?

Yes	No	Yes No		Yes No				
		Anemia	Hearing Impairments		Cystic Fibrosis			
		Heart Condition	Kidney Disease or Transplant		Blindness			
		Rheumatic/Scarlet Fever	Hepatitis or Liver Disease Other Condition					
		Cancer, Malignancies or Leukemia	Child Abuse					
		Asthma	Infection					
		Diabetes	Cleft Lip/Palate					
		Epilepsy, Seizures or Convulsions	Cerebral Palsy					
		Hyperactivity/ADD	Birth Defects					
		Psychiatric Care	Developmentally Delayed Tuberculosis or Previous Positive Test Autism Hemophilia					
		Latex Allergy or Sensitivity						
		Pain in Jaw Joints						
		Excessive Bleeding						
		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?)						
		Is your child allergic or has your child ever had an adverse reaction to a specific medication? (If yes, which?)						

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

Type of doctor Name Office Phone:

### **DENTAL HISTORY**

Parent / Legal Guardian Signature

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

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Yes N	lo	Yes No						
	Bad Breath/Halitosis		Dental Infection or Abscess					
	Bleeding Gums		Rece	nt Dental Pain				
	Stained and Discolored	teeth	Missir	ng or Extra Teeth				
	Cold Sores or Fever Bli	sters	Thum	b/Finger Sucking				
	Dry Mouth	Dry Mouth Dental Grinding/Clenching						
	Do you wish to talk to	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, pleas 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				

Date