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

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!

ABOUT YOUR CHILD

Patient's Name _____ Preferred Name _____

Date of Birth _____ ☐ Male ☐ Female

Home Address _____ Home Phone _____

City _____ State South Dakota Zip Code _____

How did you hear about our office?

☐Friend _____ ☐Dr. Referral ☐Paper ☐Yellow Pages ☐Other _____

PERSONS RESPONSIBLE FOR ACCOUNT

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: _____

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 not living with the parent.

Name _____ 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 Conditions:
☐	☐	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			
☐	☐	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?)

_____

☐ ☐ 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

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)

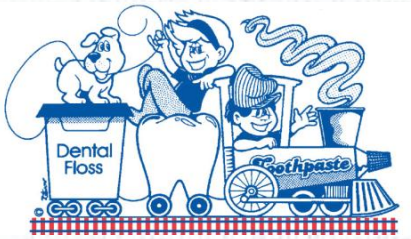
_____

☐ ☐ 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 _____



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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 doctors of Black Hills Pediatric Dentistry to do a complete and thorough examination on the patient previously named, including any diagnostic radiographs 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 have elected to only send the benefit checks directly to the policyholder. Since these two insurance carriers do not allow assignment of benefits, we have no choice but to use a different policy when assisting our patients who are covered by BC/BS and Dakotacare. Please read our Blue Cross/Blue Shield and Dakotacare letter.*) Furthermore, in the event of payment default for services previously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect on this amount.

Initial _____

Parent or Legal Guardian Signature _____ Date _____

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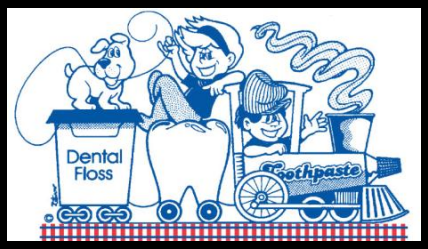

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LEGAL CONSENT TO MAKE DECISIONS

PATIENT'S NAME _____

As a convenience, we would like to offer you a chance to provide Black Hills Pediatric Dentistry and its staff with a list of individual(s) that may accompany your child to subsequent visits. Listing an individual will automatically 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 oral 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. Please remember, individuals that are permitted to make treatment decisions will also be responsible for any incurred payment changes.

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. Please also remember any individuals accompanying your child to an appointment will also be responsible for additional charges incurred during that particular visit.

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.

Parent or Legal Guardian Signature _____ Date _____

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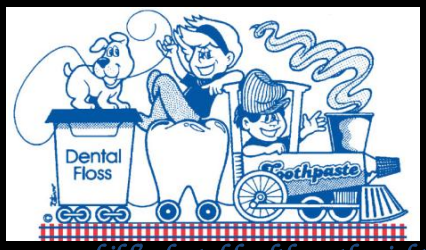

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CONSENT STATEMENTS

PATIENT'S NAME _____

The following consent statement refers to documents containing information regarding specific principles of Black Hills Pediatric Dentistry. Please sign this statement only after carefully reading such information. This informative document should be retained for future reference.

BLACK HILLS PEDIATRIC DENTISTRY CANCELLATION PROCEDURE

We are committed to the success of your child's dental treatment and want to provide you with the best service available. We are a practice specializing in the treatment of young children and there are a limited number of appointments available to provide care. There are far more children needing this care than we have space for. If you do not keep an appointment or cancel within 48 hours, this causes multiple problems. It delays the treatment to be provided to your child and increases the chances that your child's dental treatment needs will become more severe and require more extensive treatment. It also deprives another child who requires similar care from receiving their care and causes them to suffer with toothaches and other dental problems. It is extremely important that if you cannot make the appointment for your child's treatment needs, that you notify our office immediately that you will not be coming for the appointment.

*I have read the form entitled, "**Cancellation Procedure**" and understand its contents. Therefore, I take full responsibility for the cancellation of any needed appointments and am aware that without 48-hour prior notification or a valid reason, a $50 deposit for Recares and a $150 deposit for Treatment will be incurred as a **deposit to reschedule.** This deposit will be refundable to me if I keep the new appointment and any subsequent appointments necessary for my child's dental treatment. If I no-show for any further appointments, then the deposit becomes non-refundable and stays with Black Hills Pediatric Dentistry.*

Parent or Legal Guardian Signature _____ Date _____

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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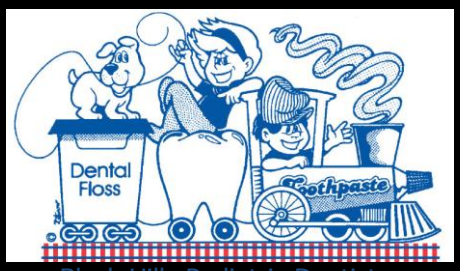

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New Patient Information For Our Parents

Dear Parent,

We welcome you and your child to our practice. We appreciate the opportunity to apply our care, skill and judgment to your child's total dental needs. Recognizing that our office represents a new experience for you and your child, we offer the following information about our office.

Along with the American Academy of Pediatric Dentistry and American Academy of Pediatrics, we recommend that the first dental examination be by 12 months of age. Many problems, which might develop otherwise, may be prevented. A thorough prevention program is the most important reason to begin pediatric care. Cavities at an early age is not uncommon, and the earlier the dental visit, the earlier prevention can begin. In much the same way your Pediatrician is trying to give your child the best possible start physically in life, we feel the same way about the oral cavity. Early examination and counseling is the best way to ensure your child gets the best possible dental start which will hopefully carry them into adulthood.

"Baby teeth" (primary teeth) are just as important as permanent teeth for chewing, speaking, and appearance. In addition, the primary teeth hold the space in the jaws for the permanent teeth. Both primary and permanent teeth help give the face its shape and form. These teeth can develop decay and infection in the same manner as adult teeth resulting in pain. If lost prematurely, nearby teeth can tip or move into the vacant space. This can cause space problems for the adult teeth, which may require orthodontic treatment to correct. So, lets keep those "baby teeth" healthy!

Before the first visit

If necessary, discuss the positive aspects of dentistry with your child. Convey good feelings about dental visits. Expect your child to react well and enjoy the first visit to our office and chances are he/she will do exactly that. Here is some additional advice:

D o ' s :

*On the day of the visit, say only that "we are going to see the dentist and they are going to count your teeth and clean them." If other questions arise, tell your child you do not have the answers, but to ask us. This way, inadvertent comments that may provoke fear or anxiety in your child may be avoided.

*Tell us about your child before the appointment, including any special needs or medical issues.

Do Not:

*Do not make any promises about what the dentist "will" or "will not" do.

*Do not encourage your child to hear stories, good or bad, about the experiences others have had with their dentist. What might be a "good" story to one child may build anxiety or fear for another.

*Do not communicate your own fears to your child

*Do not use bribery or threats to encourage good behavior.

*Do not use negative words such as "hurt". "shot", "pull", "drill", or "cavity" in front of your child

*Do not threaten your child with the work that we may or may not have to do for any reason.

Medical History Form:

Please complete the enclosed or our online medical history form and bring it with you for the first appointment. For your child's safety and in order to provide them with optimum treatment we will ask that you fill out a new medical history form every two years. If you need additional forms please go to our website at bhpediatricdentistry.com.

Your Child's Visit:

Your child's first visit will consist of an examination, and only if necessary, digital (X-rays) images taken. If appropriate a cleaning and a topical fluoride treatment will be accomplished. Consultation with the Doctor, oral hygiene instructions and any subsequent necessary visits will be discussed.

Although you may try to help your child with their dental experience, it would be in their best interest if you allow the doctor to guide your child. When there is more than one person speaking at a time often children become confused, and it is not unusual for the parent to inadvertently agitate or promote anxiety. We are specially trained to avoid those words and actions that may upset your child. Therefore we find that most children do better without their parents, and it allows us an opportunity to establish rapport with your child. If we determine that your presence is necessary, the examination would be greatly enhanced if you assume the role of a silent observer. Our objective is to gain your child's confidence and overcome any apprehension.

For the safety and privacy of all patients, other adults or children not seen at this appointment should remain in the reception room. Children in the reception room will need a supervisory adult with them.

Please do not be upset if your child cries. Children are often afraid of anything new and strange, and crying is a normal reaction to fear of the unknown. Our training helps us to address your children's fears in such a way as to guide their behavior in a constructive direction. As your child's familiarity with our office and procedures increases, their experiences will become more positive. An accounting of services to be rendered and the costs involved will be given to you should your child need to return for treatment.

Scheduling Guidelines

We are aware of school policies, which make it more difficult for children to be out of school for any reason. However, medical and dental appointments are EXCUSED ABSENCES with a doctor's school pass and signature stating the child was in the office.

Although we would like to see all school-aged patients after school, this is not always possible. Therefore, to make certain everyone has a fair share of after school appointment, the following guidelines have been set. Please help us help your child.

1. Children under the age of five years old will be scheduled in the morning only.
2. Operative Appointments will be scheduled as needed and as specified by our Doctors. These appointments fill up fast therefore we can not guarantee a after school time for your school age child.
3. Coming late for an appointment may require rescheduling so we do not keep other patients waiting. Please call if you are going to be late and we will try to work you back into the schedule if it is possible.
4. If you can not keep your appointment, give us 48 hours notice. This courtesy makes it possible to give your appointment time to another patient who needs to see the doctors. Our verification messages are courtesies. Keeping the scheduled appointment time is your obligation. If an appointment needs to be changed or canceled please give our office at least 24 hours in advance in order to avoid a broken appointment charge of $50.00 per child.

"Children's Time"

Our objective is to always get patients in at the time scheduled. As parents, you are well aware that children do not always allow us to achieve the goals planned for them as intended. In Pediatric

Dentistry those obstacles are much more magnified by virtue of the nature of the work. Our office operates on "children's time" will invariably cause some delays. Because of this, we do apologize for running behind, occasionally. Be reassured that we are taking care of your child in the same kind of caring manner.

Infectious Disease Control

When you visit our office, you will observe the many measures practiced by the doctors and our team to ensure the security or your child's health. We take pride in the fact that we exceed the standards of sterilization guidelines established by the CDC.

Emergency Care

If an emergency arises and it is after business hours you will be advised of a number you may call on our night message. This number is to our on call service whom will get into contact with the doctor on call and they will respond to you in a short period of time.

In the event of an emergency during office hours, our office will do there best to get your child in and seen as soon as possible. We may not be able to complete treatment on the day we get your child in but we will do our best to get your child out of pain so that they may be put into a scheduled time slot. Please accept our apologies ahead of time and understand that we have frequent unscheduled pain or accident appointments, therefore there may be on occasion delays in your child's appointment.

Recare and Operative Visits

We hope that you share in our belief that regular preventive dental health care is a sound investment. While the responsibility for returning for this treatment rest with you, we will provide the service of contacting you when it is time to return. At this time of your recall visit, please advise the office of any changes in address, telephone number, health or medications your child may be taking.

If a caregiver brings your child and you do not have them listed on our legal consent form, please provide the permission for us to do all that is necessary for a particular visit. Please provide them with the pertinent history changes and permission for any treatment necessary. Should you have specific instructions or requests provide them in writing. If there are any questions concerning the visit, feel free to contact our office.

Which Doctor will I be seeing?

Many of the children see all the doctors. This is beneficial in that it enables you and your child to feel comfortable with them if one is unavailable and will help to expedite treatment. It will also help your scheduling of appointments. Although many of our patients are very satisfied with each member of our group, we will be more than happy to fulfill your request to see a specific doctor. Because certain days and hours are reserved by many of our parents in advance we would appreciate flexibility on your part in that request. If your child requires immediate attention, it may be in their best interest to see the doctor who can accomplish treatment in the most expeditious manner.

Payment

Please be aware that the parent or caregiver bringing the child to our office is legally responsible for payment of all charges. We cannot send statements to others. As a courtesy our office will file **most** insurance claims. You are responsible for all co-payments or balance due at the time of your child's visit.

Black Hills Pediatric Dentistry.com

Visit our website for additional information regarding our office and the dental health of your child. We look forward to seeing you soon!

Black Hills Pediatric Dentistry, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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 i

_____

{Please Print **Patient**(s) Name}

_____ _____

{Signature ~ Parent or Guardian} {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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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