BLACK HILLS pediatric DENTISTRY

Where Bright Smiles Begin

PATIENT REGISTRATION AND MEDICAL/DENTAL HISTORY

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 _____ Zip Code _____

How did you hear about our office?

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

PERSONS RESPONSIBLE FOR ACCOUNT

PARENT OR LEGAL GUARDIAN INFORMATION

Name: _____ Date of Birth: _____

Mailing Address: _____ Social Security #: _____

City, State, ZIP: _____ Home Phone: _____

Employer: _____ Work Ph: _____

E-Mail Address: _____ Cell Ph: _____

PARENT OR 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/Low Blood Count	☐	☐	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	☐	☐	Food Allergies? To what? Especially eggs. _____			

☐ ☐ 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 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. Since these two insurance carriers do not allow assignment of benefits, we must 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.*) 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.

Parent or Legal Guardian Signature _____ Date _____

700 Sheridan Lake Road • Rapid City, SD 57702 • Phone (605) 341-3068 • Fax (605) 341-5757

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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 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. 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 remember that individuals accompanying your child to an appointment will 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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pediatric
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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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