



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
Relationship to Patient: Mom Dad Stepmom Stepdad Foster Parent Guardian Other _____
Mailing Address: _____
City, State, Zip Code: _____
Employer: _____
E-Mail Address: _____
Date of Birth: _____
Social Security #: _____
Home Ph: _____
Work Ph: _____
Cell Ph: _____

*PARENT OR LEGAL GUARDIAN INFORMATION

Name: _____ Male Female
Relationship to Patient: Mom Dad Stepmom Stepdad Foster Parent Guardian Other _____
Mailing Address: _____
City, State, Zip Code: _____
Employer: _____
E-Mail Address: _____
Date of Birth: _____
Social Security #: _____
Home Ph: _____
Work Ph: _____
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

- Food Allergies? (especially eggs)? _____
- Allergic to any medications? _____
- Bad reaction to any medications? _____
- Latex Allergy or Sensitivity? _____
- Eczema / any other skin conditions?
- Is the patient currently taking any medication(s)?
If yes, Please list: _____
- Rheumatic or Scarlet Fever?
- Heart Condition / Hear Murmur. If "Yes" to either:
has your child's doctor recommended antibiotics
prior to dental care? _____
- Has your child ever been hospitalized? _____
- Has your child ever had surgery? _____
- MRSA (Methicillin-resistant staphylococcus aureus)
- Asthma / Reactive Airway Disease?
- Does you child use a nebulizer? If so, how often? _____
- Snoring
- Malignant Hyperthermia?
- Premature? _____ weeks
- Immunizations Current?

Yes No

- Cystic Fibrosis
- Tuberculosis
- Cerebral Palsy
- Developmentally Delayed
- Visually Impaired / Blindness
- Epilepsy, Seizures or Convulsions
- Hyperactivity / ADD / ADHD
- Autism
- Psychiatric Care
- Child Abuse
- Hearing Impairment
- Birth Defects
- Cleft Palate
- Kidney Disease or Transplant
- Diabetes
- Hepatitis or Liver Disease
- Anemia / Low Blood Count
- Other Conditions
- Is your child currently under the care of a doctor?
- If so, why? _____

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

- Bad Breath/Halitosis
- Bleeding Gums
- Stained and Discolored Teeth
- Cold Sores or Fever Blisters
- Dry Mouth
- 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):

Yes No

- Dental Infection or Abscess
- Recent Dental Pain
- Missing or Extra Teeth
- Thumb/Finger Sucking
- Dental Grinding/Clenching

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 _____

700 Sheridan Lake Road • Rapid City, SD 57702-2407

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

email: info@bhpdsc.com

www.bhpediatricdentistry.com



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 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.

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 _____