Black Hills Pediatric Dentistry
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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 _____