Black Hills Pediatric Dentistry
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www.bhpediatricdentistry.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 _____ Zip Code _____

How did you hear about our office?

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

PERSONS RESPONSIBLE FOR ACCOUNT

GUARANTOR'S INFORMATION

Name: _____ Date of Birth: _____

Mailing Address: _____ Social Security #: _____

City, State, ZIP: _____ Home Phone: _____

Employer: _____ Work Ph: _____

E-Mail Address: _____ Cell Ph: _____

ADDITIONAL GUARANTOR'S 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	
☐	☐	Anemia	☐	☐	Hearing impairment
☐	☐	Heart Condition _____	☐	☐	Sexually Transmitted Disease
☐	☐	Is Pre-Med necessary?	☐	☐	Kidney Disease or Transplant
☐	☐	Rheumatic Fever or Scarlet Fever	☐	☐	Liver Disease or Transplant
☐	☐	Bruise or Bleeds Easily	☐	☐	Hepatitis or Jaundice
☐	☐	Asthma or Lung Problems	☐	☐	Stomach Disorder
☐	☐	Pneumonia date(s) _____	☐	☐	Thyroid Disorder
☐	☐	Cancer, Leukemia, or Lymphoma	☐	☐	Currently Pregnant
☐	☐	Diabetes	☐	☐	Implanted Shunts, Pins, Screws, or Rods
☐	☐	Seizures, Epilepsy, or Convulsions	☐	☐	Physical or Emotional Abuse
☐	☐	Fainting Spells	☐	☐	Ear Infection
☐	☐	User of Tobacco Products	☐	☐	Cleft Lip/Palate
☐	☐	Drug or Alcohol Abuse	☐	☐	Learning Disability
☐	☐	Emotional or Behavioral Problems	☐	☐	Handicaps or Disabilities
☐	☐	ADD/ADHD	☐	☐	Congenital Birth Defects/Syndrome
☐	☐	Psychiatric Problems	☐	☐	Tuberculosis or Previous Positive Test
☐	☐	Seasonal Allergies/Hay Fever	☐	☐	Delayed Development *(Approx. Age Function____)*
☐	☐	Latex Allergy or Sensitivity	☐	☐	Any Stay(s) in Hospital *(date(s)_____)*

Are all immunizations current? ☐ Yes ☐ No

Is your child taking any medication(s)? ☐ Yes ☐ No If so, please list _____

Is your child currently under the care of a physician? ☐ Yes ☐ No If so, for what? _____

Does your child have any allergies to medications? ☐ Yes ☐ No If so, which? _____

PLEASE LIST ANY TREATING PHYSICIAN (I.E. PEDIATRICIAN)

TYPE OF PHYSICIAN _____ NAME _____ OFFICE PHONE: _____

DENTAL HISTORY

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

Yes	No		Yes	No	
☐	☐	Bad Breath / Halitosis	☐	☐	Popping or Soreness of Jaws
☐	☐	Bleeding/Swollen Gums	☐	☐	Dental Infection or Abscess
☐	☐	Stained/Discolored Teeth	☐	☐	Pain from Teeth
☐	☐	Cold Sores or Fever Blisters	☐	☐	Missing or Extra Teeth
☐	☐	Tooth Grinding	☐	☐	Injury to Teeth, Mouth or Face
					If so, please explain _____

Does your child have anxiety about dental treatment? ☐ Yes ☐ No

Does your child receive fluoride supplementation? ☐ Yes ☐ No

Does your child brush his/her teeth daily? ☐ Yes ☐ No If so, do you assist? ☐ Yes ☐ No

Does your child suck a thumb, finger, or pacifier? ☐ Yes ☐ No

What do you expect your child's behavior to be? ☐ Cooperative ☐ Fearful ☐ Defiant ☐ Don't Know

How would you describe your child's current oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What are your primary concerns about your child's oral health? _____

Parent or Legal Guardian Signature _____ Date _____