BLACK HILLS pediatric DENTISTRY

Where Bright Smiles Begin

NEW PATIENT INFORMATION FOR OUR PARENTS

Dear Parent,

We welcome you and your child to our practice. We appreciate the opportunity and your trust in us to provide for 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 the first dental examination by 12 months of age. A comprehensive prevention program is the most important reason to begin pediatric care. Tooth decay at an early age is not uncommon, and the earlier the first dental visit, the earlier prevention can begin. 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 too soon, 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.

Before the first visit

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 they will. Here is some additional advice:

Do's:

*On the day of the visit say "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, comments that may cause 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 promises about what the dentist will or will not do.
*Do not allow siblings to scare child with "stories" about their dental experience.
*Do not communicate your own fears of the dentist to your child.
*Do not threaten your child.
*Do not use negative words such as "hurt," "shot," "pull," "drill."

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

Medical History Form:

Please complete the written or 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 the best 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, cleaning, fluoride application and X-rays if indicated. Consultation with the dentist, oral hygiene instructions and any other 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. 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 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 that make it more difficult for children to be out of school. 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 appointments the following guidelines have been set:

1. Children under five years old will be scheduled in the morning.
2. Operative appointments will be scheduled as needed and as specified by our dentists. These appointments fill up fast and we cannot guarantee 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.
4. If you cannot keep your appointment please try and give us 48 hours notice. This courtesy makes it possible to give your appointment time to another patient who needs to see the dentists. Keeping the scheduled appointment time is your obligation.

Infectious Disease Control

When you visit our office, you will observe the many measures practiced by our staff 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 after business hours you will be advised to call our after hours answering service. They will get in contact with the dentist on call and will respond to you in a short period of time. If an emergency arises during office hours, we will do our best to get your child seen as soon as possible. We may not be able to do comprehensive treatment but we will do our best to get your child out of pain.

Recare and Operative Visits

Our philosophy is that regular preventive dental care will prevent future dental disease. While the responsibility for returning for preventive treatment rests with you, we will provide the service of contacting you when it is time to return. At the 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?

We have pediatric and general dentists scheduled in the office throughout the week. Most of the children will see each of the dentists over time. Although many of our patients are very satisfied with each member of our group, we are more than happy to honor your request to see a specific dentist. Because certain days and hours are reserved by many of our patients 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 dentist 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 any balance due at the time of your child's visit.

Black Hills Pediatric Dentistry Online

Visit our website bhpediatricdentistry.com for additional information regarding our office. Thanks for choosing us and we look forward to "putting your child's dental health on the right track."

BLACK HILLS pediatric DENTISTRY

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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 _____

BLACK HILLS Pediatric DENTISTRY

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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 _____

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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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