Sugarbug dental
Children's Dentistry & Orthodontics

Name of Child_____Date_____
Date of Birth_____Age_____Sex_____
Home Address_____
Street City State Zip code
School_____Grade_____
Names and ages of other children in family_____
Parent/Guardian_____DOB_____Married/Single/Other
Cell Phone_____Email_____
Employer_____Work/Emergency Phone_____
Parent/Guardian_____DOB_____Married/Single/Other
Cell Phone_____Email_____
Employer_____Work/Emergency Phone_____
Who has legal custody of patient?_____
Person responsible for account_____SS#_____DOB_____
Dental Insurance Co._____Group #_____
Please be advised that we confirm appointments via text and email only.
Parent/Guardian must give written authorization to have another adult accompany child for future appointments. Please ask front office for Guardian Authorization form.

Whom may we thank for referring you to us?_____
What is the reason for your child's dental visit?_____
HEALTH HISTORY
□ YES □ NO Is your child in good health?
Name of Pediatrician_____Clinic/Hospital_____
Pediatrician Phone _____Date of last exam_____
□ YES □ NO Has your child ever had a health problem? _____
□ YES □ NO Has your child ever been hospitalized? Please give reasons and dates:
_____
□ YES □ NO Is your child allergic to anything? Example: Latex, Penicillin, etc.…
_____
□ YES □ NO Is your child currently taking any medications? Please give medication, dose, and reason_____
Please circle if your child has been treated for any of the following:

Heart disease/murmur	Bleeding/transfusions	Asthma/breathing
Hyperactivity	Anemia	Diabetes
Kidney disease	Rheumatic fever	AIDS/HIV
Speech/hearing	Seizures	Hepatitis
Cerebral palsy	Cleft lip/palate	Blood dyscrasias
Cancer/tumors	Congenital birth defects	Mental delays
Physical delays	Autism	Personality/social
Liver/GI disease	Frequent infections	Adverse drug rxn
Eyesight	Attention Deficit Disorder	Endocrine/growth

Please elaborate on any items circled:_____

Do you consider your child to be □ advanced in learning process
□ progressing normally □ slow in the learning process

Was your child □ breast fed □ bottle fed At what age stopped?_____

DENTAL HISTORY

□ YES □ NO Has your child ever been to the dentist? Name of dentist and date
_____

□ YES □ NO Has your child experienced any unfavorable reaction from previous dental care? Explain_____

□ YES □ NO Does your child suck a finger, thumb or pacifier?

□ YES □ NO Does your child have pain with chewing, yawning or wide opening?

Please check if your child is having problems with any of the following:
□ Cavities □ Toothache □ Teeth Sensitive □ Trauma □ Gum Infections □ Color of Teeth
□ Orthodontics □ Other
Comments:_____

FLUORIDE HISTORY

□ YES □ NO Is your home water supply fluoridated?

□ YES □ NO Does your child use fluoridated toothpaste?

□ YES □ NO Do you give your child another form of fluoride? What? _____

*Initials*_____**Cleaning:** Plaque buildup on teeth result from many types of foods. If plaque is not removed from teeth it can cause cavities and irritation to the gum tissue. Dental cleaning can also remove most stains. Much of the success of cleaning depends upon the quality of home care and oral hygiene. After the cleaning, fluoride treatment is done. Fluoride makes teeth strong and can help to prevent cavities. Your child should refrain from eating or drinking for at least 30 minutes to allow time for fluoride to take its action. If excess fluoride is digested, vomiting may occur.

*Initials*_____**X-rays:** X-rays will be necessary before any diagnosis can be finalized. If any decay or dental infection (abscess) is obvious on visual inspection, x-rays will be necessary to assess the extent of damage to the tooth structure.

CONSENT FOR DENTAL TREATMENT

I request and authorize Dr. Begian/Dr.McClory/Dr.Tirgari/Dr.Negar/Dr.Nara/Dr.Sahar/Dr. Danesh/Dr.Banty or assistants to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Begian/ Dr.McClory/Dr.Tirgari/Dr.Negar/Dr.Nara/Dr.Sahar/Dr.Danesh/Dr.Banty to diagnose and/or treat my child's dental problems.I will allow photographs to be taken of my child or child's teeth for diagnostic purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age.

Dr.Begian/Dr.McClory/Dr.Tirgari/Dr.Negar/Dr.Nara/Dr.Sahar/Dr.Danesh/Dr.Banty will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature_____ Date _____
Parent/Legal Guardian