Sugarbug dental & Orthodontics

New Patient Information

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 ______________________

2nd Parent/Guardian ______________________ DOB __________ Married / Single / Other
Cell Phone ______________________ Email ______________________
Employer ______________________ Work/Emergency Phone ______________________

Who has legal custody of the patient? ______________________________
Person responsible for the account ______________________ SSN ____________ DOB ______
Dental Insurance Provider ______________________ 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? Please explain:
____
▫ 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	Speech/hearing	Physical delays
Bleeding/transfusions	Seizures	Autism
Asthma/breathing	Hepatitis	Personality/social
Hyperactivity	Cerebral palsy	Liver/GI disease
Anemia	Cleft lip/palate	Frequent infections
Diabetes	Blood dyscrasias	Adverse drug rxn
Kidney disease	Cancer/tumors	Eyesight
Rheumatic fever	Congenital birth defects	Attention Deficit Disorder
AIDS/HIV	Mental delays	Endocrine/growth

Please elaborate on any items circled: ______________________________

Do you consider your child to be:
- ◻ progressing normally
- ◻ advanced in learning process
- ◻ slow in 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 you 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.Danesh/Dr.Mascagno 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.Danesh/Dr.Mascagno 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.Danesh/Dr.Mascagno 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