James R. Delaney, D.D.S.

Specialist in Pediatric Dentistry

Randall E. Root, D.D.S.

Specialist in Orthodontics for Children & Adults

Patient Information ***PLEASE FILL OUT COMPLETELY*** Acct. No._____

Patient's Last Name		First Name	Mid. Int.	Nickname	Birthdate (Mo, Day, Yr)
Sex	No. of Siblings	Email Address	Home Phone No.	Who does child live with?	
Street Address			City, State, Zip Code		
Has any member of family been here before?		If yes, name and approximate date of last visit.		Who may we thank for referring you to our office?	

Father's Information

Father's Last Name	First Name	Mid. Int.	Home Phone No.	Birthdate (Mo, Day, Yr)
Street Address		City, State, Zip Code		
Cell Phone	Social Security Number	Email Address		
Employed By	Business Address	Business Phone		Position/Department
Father's Dental Insurance	Insurance ID number		Marital Status	Spouse's Name

Mother's Information

Mother's Last Name	First Name	Mid. Int.	Home Phone No.	Birthdate (Mo, Day, Yr)
Street Address		City, State, Zip Code		
Cell Phone	Social Security Number	Email Address		
Employed By	Business Address	Business Phone		Position/Department
Mother's Dental Insurance	Insurance ID number		Marital Status	Spouse's Name

Additional/Secondary Dental Insurance Information

Insured Party's Last Name	First Name	Mid. Int.	Relationship to Patient	Birthdate (Mo, Day, Yr)
Insured Party's Dental Insurance	Insured Party's Social Security		Insured Party's Employer	

Emergency Information - Person to contact in case of an emergency, other than parent

Name	Phone No.	Relationship to Patient

OVER

Primary Care Physician or Pediatrician_____ Family Dentist_____

Does your child have any dental complaints?_____

Has your child had any previous dental experience?_____

MEDICAL INFORMATION

Yes No

- ❒ ❒ Does your child have any mental or emotional problems?_____
- ❒ ❒ Does your child have a physical handicap?_____
- ❒ ❒ Does your child have any allergies?_____
- ❒ ❒ Has your child had any serious operations/illnesses?_____
- ❒ ❒ Is your child taking any medications or under the care of a physician?_____
  _____
- ❒ ❒ Is your daughter taking any form of Contraceptive Medication, (birth control pills) at this time? (Some prescribed antibiotics may interfere with the effectiveness of the birth control medication).

Does your child have a history of any of the following?

Yes No

- ❑ ❑ Reflux/Stomach Disorders
- ❑ ❑ Anemia/Bleeding Disorders
- ❑ ❑ Epilepsy/Seizures
- ❑ ❑ Diabetes
- ❑ ❑ Attention Deficit Disorder/ADHD
- ❑ ❑ Asthma/TB /Respiratory Infections/RSV
- ❑ ❑ Heart Murmur/Rheumatic Fever/Heart Disorders

Yes No

- ❑ ❑ Cerebral Palsy
- ❑ ❑ Brain or Nerve Damage
- ❑ ❑ Kidney Disorders
- ❑ ❑ Hepatitis/Liver Disorders
- ❑ ❑ Aids or HIV Positive
- ❑ ❑ Shunt *type* _____

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN FULLY BELOW:

PLEASE NOTE THAT ANY CHANGES IN YOU CHILD'S HEALTH STATUS SHOULD BE REPORTED TO OUR OFFICE AT THE EARLIEST POSSIBLE TIME

AUTHORIZATION FOR TREATMENT OF A MINOR: Because your child is a minor, signed permission is required from a parent or guardian before any dental service can be rendered.
The doctors are given permission to use their professional judgment in patient management regimes as they feel necessary. This authorization includes radiographs, photographs and all necessary treatment.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the information and have completed this form. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes.

We appreciate your efforts in keeping scheduled appointments; however, if you must cancel, please do so 24 hours prior to the appointment time or a $50 fee will be charged.

Signature_____ Date_____

❑ Parent ❑ Legal Guardian ❑ Other

I hereby authorize payment of the dental benefits otherwise payable to me directly to Drs. Delaney, Root & Associates, P.C.

Signature_____ Date_____

❑ Parent ❑ Legal Guardian ❑ Other