

Welcome

Dr. Deryl W. Drum
317 Tamarack Lane
Shiloh, IL 62269



Health History Form

Today's Date: _____

NOTE: The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name _____
Last First MI

Goes by: _____ Male Female

Siblings that we treat _____

Child's Birthdate ____/____/____ Child's Age _____

School _____ Grade _____

Child's Home # (_____) _____

SS# _____

Child's Home Address: _____

City _____ State _____ Zip _____

2. Who may we thank for referring you to our office?

3. Mother's Information

Name _____

Mother Stepmother Guardian Birthdate ____/____/____

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

(Please star the preferred daytime phone number.)

SS # _____ DL# _____

Email _____

4. Father's Information

Name _____

Father Stepmother Guardian Birthdate ____/____/____

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

SS # _____ DL# _____

Email _____

(Please star the preferred daytime phone number.)

5. Who is Accompanying the Child Today?

Name _____

Relationship _____

Do you have legal custody of this child? Yes No

6. Person Responsible for Account

Name _____

Relationship _____

Billing Address _____

City _____ State _____ Zip _____

Home # (_____) _____

Work # (_____) _____

Cellular # (_____) _____

E-mail _____

7. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____/____/____

Social Security # _____

Policy Owner's Employer _____

8. Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____/____/____

Social Security # _____

Policy Owner's Employer _____

9. Dental History

Is this your child's first visit to the dentist? _____

If not, how long since the last visit to the dentist? _____

Previous Dentist's Name _____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain _____

Why did you bring your child to the dentist today? _____

Does your child have any of the following habits?

Y N Lip Sucking / Biting Y N Nail Biting

Y N Nursing / Bottle Habits Y N Thumb / Finger Sucking

Has your child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain _____

Is your child's water fluoridated? Yes No

Is your child taking fluoride supplements? Yes No

Has your child ever had any pain or tenderness in his/her jaw/ joint? (TMJ/TMD)? Yes No

Does your child brush his/her teeth daily? Yes No

Floss his / her teeth daily? Yes No

10. Health History

Has your child ever had any of the following conditions?

Y N Abnormal Bleeding Y N Disabilities/Special Needs

Y N Allergies to any Drugs Y N Hearing Impairment

Y N Any Hospital Stays Y N Heart Disease/Murmur

Y N Any Operations Y N Hemophilia/Blood Disorders

Y N Asthma Y N Hepatitis

Y N Cancer Y N HIV + / AIDS

Y N Congenital Birth Defects Y N Kidney/Liver Conditions

Y N Convulsions/Epilepsy Y N Rheumatic/Scarlet Fever

Y N Allergies to Latex Product Y N Diabetes

Y N Tuberculosis Y N Pregnancy/Hormone Disorder

Y N Sickle Cell Disease/Traits Y N ADD/ADHD

Please discuss any serious medical conditions your child has had

Please list all drugs your child is currently taking _____

Please list all drugs and materials your child is allergic to _____

Child's Physician _____

Phone (_____) _____

Is your child currently under the care of a physician? Yes No

Please describe your child's current physical health...

Good Fair Poor

11. I, the undersigned, have completed the health history questionnaire and certify that the preceding information is true and correct. This office will not be held responsible for any problems arising out of inadequate information not disclosed. I grant authority to All Grins 4 Kids to perform all procedures and treatments in the patient's best interest.

Signature of Parent or Guardian

Date

Relationship to Patient

I authorize the doctor named above to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents. I authorize release or any information related to any claims to all my insurance companies or other relevant parties. I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I authorize payment of health benefits otherwise payable to me, directly to my doctor.

I permit a copy of this authorization to be used in place of the original. This "Signature on File" is valid until withdrawn in writing.

Signature of Beneficiary, Guardian or Personal Representative

Date

Relationship to Child: _____

I have been informed of All Grins 4 Kids Notice of Privacy Practices. I have read and understand that this notice describes how medical information may be used and disclosed. I also understand that this notice may be changed from time to time to make the revised notice effective for all protected health information.

Signature

Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA through Compliance Management Systems.