32 South Behi Street
Appleton, MN 56208
(320) 289-2241

The following information is requested to enable us to give you the most consideration of your time and feelings. In order for any doctor to thoroughly diagnose any condition, he must have accurate answers so that he may give personal attention to each individual.
Thank You.

GENERAL INFORMATION:

Date ____________

CHILD'S NAME ____________ NICKNAME ____________

CHILD'S AGE ____________ BIRTHDATE ____________ SCHOOL ____________ GRADE ____

PARENT'S NAME ____________ HOME PHONE ____________

HOME ADDRESS ____________ ZIP ____________

FATHER EMPLOYED ____________ BUSINESS PHONE ____________

MOTHER EMPLOYED ____________ BUSINESS PHONE ____________

WHO IS RESPONSIBLE FOR THIS ACCOUNT ____________

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE ____________

IS YOUR CHILD COVERED BY ANY DENTAL INSURANCE PLAN? YES ____________ NO ____________

Insured's name ____________ Policy No. ____________

Insurance Company Name ____________ Social Security No. ____________

Effective date ____________ Group Name ____________ Group No. ____________

IS YOUR CHILD COVERED BY ANY MEDICAL ASSISTANCE PROGRAM (WELFARE)? YES ____________ NO ____________

Patient's Number ____________ County ____________

CHILD'S HISTORY:

Is your child having any particular dental problems? ____________

How long since he last visited a dentist? ____________

What was done at that time? ____________

Has your child experienced any unfavorable reaction from any previous dental or medical care? ____________

Are you interested in preventing further decay by having regular dental check-ups and fluoride treatments? ____________

Is your child under the care of a physician? ____________

Name of Family Physician or Pediatrician? ____________

Does your child take any medicines? ____________

Is there any reason why you would consider your child not to be in good health? ____________

Additional Comments: ____________

Parent's Signature ____________