Name: _____

Preferred Name: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

SSN: _____ DOB: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

Employer: _____ Occupation: _____

How did you hear about the office: _____

Do you prefer to be contacted for appointment confirmation via e-mail or phone? _____

Insurance - Primary

Subscriber Name: _____ Relationship to Patient: _____

Subscriber SSN/ID: _____ Subscriber DOB: _____

Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

Insurance - Secondary

Subscriber Name: _____ Relationship to Patient: _____

Subscriber SSN/ID: _____ Subscriber DOB: _____

Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

Assignment and Release

I, the undersigned, certify that I (or my dependant) have insurance coverage and assign directly to all insurance benefits, if any, otherwise payable to me for my services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions

Responsible Party Signature: _____

Relationship: _____ Date: _____

MOLLDREM
FAMILY DENTISTRY

Molldrem Family Dentistry
800 Prairie Center Dr. Suite 250
Eden Prairie, MN 55344

CALL: 952.974.5116

Do you have a personal physician?
Physician's Name: _____
Physician's Phone: _____
Date of last visit? _____
Your current physical health is: ☐ Good ☐ Fair ☐ Poor
Are you currently under the care of a physician? ☐ Yes ☐ No
Do you use tobacco in any form? ☐ Yes ☐ No
Have you had any metal rods, pins or implants placed? ☐ Yes ☐ No
Are you taking any medications? ☐ Yes ☐ No
Please list each one: _____
Have you ever had any surgical procedures? ☐ Yes ☐ No
Please list each one: _____

Yes	No	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Frequent Headaches
☐	☐	Glaucoma
☐	☐	HIV + AIDS
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	High Blood Pressure
☐	☐	Joint Replacement
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic
☐	☐	Seizures
☐	☐	Sickle Cell disease
☐	☐	Sinus Problems
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers

Yes	No	Allergies
☐	☐	Aspirins
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Yes	No	If Female, Please Answer
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If so, # of weeks _____
☐	☐	Are you nursing?

Emergency Contact: _____ Relationship: _____
Address: _____ Phone: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

MOLLDREM
FAMILY DENTISTRY

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800 Prairie Center Dr. Suite 250
Eden Prairie, MN 55344

CALL: 952.974.5116

How may we help you today? _____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you had any pain/discomfort in your jaw joint?(TMJ) ☐ Yes ☐ No

Are you under stress? (New job, moving, relationships) ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Is there anything you would like to change about your smile? ☐ Yes ☐ No

Are you happy with the color of your teeth? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

How many times do you: floss/day? _____ brush/day? _____

Are your teeth sensitive to heat, cold, chewing or anything else? ☐ Yes ☐ No

Do you ever have canker sores or cold sores? ☐ Yes ☐ No

Have you ever have a serious/difficult problem with any previous dental work? ☐ Yes ☐ No

Have you ever had any unfavorable dental experiences? ☐ Yes ☐ No

When was your last dental cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

Do you feel nervous about having dental treatment? _____

How can we accommodate you better during your dental visit? _____

Here at Molldrem Family Dentistry we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Zoom Tooth Whitening
Sealants
Partials/Dentures
Veneers
Smile Makeover
Crown and Bridge
Night/Sport Guards
Invisalign/Orthodontics
Bonding
Implant Crowns

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Financial Expectations

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need. We are available to answer your questions or to assist you in any way we can.

Initial

_____ * Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any dental questions regarding your dental benefits, please contact your employer or insurance company directly. Dental benefit plans almost always never pay for 100% of your dental care. It is only meant to assist you.

_____ * We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment given by a company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up to date information we have, but it is ONLY AN ESTIMATE.

_____ * We bill your insurance company as a courtesy to you. If insurance does not pay within 90 days or denies your claim, Molldrem Family Dentistry reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare, as we make every effort to receive payment from insurance. *** If you do not have dental insurance, payment for all services is required prior to the time of treatment.

_____ * Molldrem Family Dentistry requires payment for services or out of pocket portions not covered by insurance prior to treatment. We require 50% of your portion when you schedule your treatment and the remaining 50% on the day your appointment. (This can be refunded if you decide not to have the work done.) We accept VISA, Mastercard, Cash, Check and CareCredit*. If you are interested in an extended finance option, we work with CareCredit* to office 3,6,12, & 18 months interest free terms or longer terms with a lower interest rate.

_____ * A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointment. If you must change your appointment, we require 24 hours notice to avoid a $50/hr cancellation fee (emergencies are an exception.)

_____ * Finance charges can be applied to all past due amounts at the rate of .75% per month. After 90 days of an unpaid outstanding balance, your account may be transferred to another means of collections and you will be responsible for a collection fee of 35% of your outstanding balance and 50% if an attorney is used.

I agree with the above conditions.

Print Name: _____

_____ _____

(Signature) (Date)

**Application must be completed and approved for CareCredit option.*