DAVID J. FELGENHAUER, D.D.S.

The Following Information Is Confidential and for Our Records Only!!!

(Please Print)

PATIENT INFORMATION

Date: ____________

Patient: ____________ Age: ______

☐ Male
☐ Female

☐ Single
☐ Married
☐ Widow
☐ Divorced

Date of Birth: ____________ Social Sec. #: ____________

Home Addresss: ____________ Home Phone: ____________

Apt. #: ______ City: ____________ State: ______ Zip: ______

Person to Pay Bill Today: ____________ Relationship: ____________

Type of Payment Today: ☐ Cash ☐ Check ☐ Credit Card

Employer: ____________ Business Phone: ____________

Business Address: ____________

INSURANCE INFORMATION

First Insurance Co.: ____________ Group #: ____________ ☐ Dental ☐ Medical

Name of Insured: ____________ Social Sec. #: ____________ Relationship: ____________

Date of Birth: ____________

Second Insurance Co.: ____________ Group #: ____________ ☐ Dental ☐ Medical

Insured Name: ____________

Date of Birth: ____________ Social Sec. #: ____________ Group #: ____________ Relationship: ____________

Referred By: ____________

Name of Dentist: ____________

IT IS ESSENTIAL TO YOUR TREATMENT THAT YOUR ANSWERS TO THE FOLLOWING CONFIDENTIAL MEDICAL QUESTIONS BE TRUTHFUL AND COMPLETE!

	YES	NO
1. Have you ever had an **allergic** reaction to **any drugs**, **medicines**, or **foods**?	☐	☐
a) If yes, please state item and describe briefly type of reaction: ____________		
2. List any prescribed medication you are presently taking, include over-the-counter and herbal supplements as well. Especially note any taken within the past 24 hours. ____________		
3. Do you use recreational drugs?	☐	☐
a) If yes, please state type of drug and approximately how many times per week: ____________		
4. Have you ever been treated for drug or alcohol-related problems?	☐	☐
a) If yes, please state when: ____________		
5. Do you smoke or use chewing tobacco?	☐	☐
6. Have you had any respiratory problems or colds recently?	☐	☐
7. Have you ever had any type of surgery?	☐	☐
a) If yes, please state type and year: ____________		
8. Have you ever been "put to sleep" for any surgery?	☐	☐
9. Did you have any complications associated with being "put to sleep" (i.e., nausea, trouble waking up, etc.)?	☐	☐
a) If yes, please state associated problem: ____________		
10. Have you ever had any excessive bleeding problems requiring special treatment, or do you take prescribed blood thinners or excessive amounts of aspirin?	☐	☐
a) If yes, please state: ____________		

*** *PLEASE COMPLETE MEDICAL HISTORY ON REVERSE SIDE* ***

	YES	NO
11. Have you ever had a blood transfusion?	☐	☐
12. Have you ever had or been told you are a carrier of a disease (i.e., Hepatitis, Tuberculosis, AIDS, etc.)?	☐	☐
13. Have you been under the care of a doctor (M.D.) during the past two years?	☐	☐
14. Have you been hospitalized or treated in a hospital during the past two years?	☐	☐

11. Have you ever had a blood transfusion? ☐ YES ☐ NO
    When: ____________________

12. Have you ever had or been told you are a carrier of a disease (i.e., Hepatitis, Tuberculosis, AIDS, etc.)? ☐ YES ☐ NO
    a) If yes, please state disease and when: ____________________

13. Have you been under the care of a doctor (M.D.) during the past two years? ☐ YES ☐ NO
    a) If yes, please state:
    Why ____________________
    When ____________________
    M.D. ____________________

14. Have you been hospitalized or treated in a hospital during the past two years? ☐ YES ☐ NO
    a) If yes, please briefly state why?
    ____

15. Please check any of the following which you have or have had:

☐ Heart Trouble	☐ Asthma Cough	☐ Mononucleosis
☐ Angina (Chest Pains)	☐ Seizures	☐ Hemophilia
☐ High Blood Pressure	☐ Tuberculosis	☐ Cancer
☐ Rheumatic Fever	☐ Hepatitis	☐ Radiation or Chemotherapy
☐ Rheumatoid Arthritis	☐ Jaundice	☐ Persistent Cough
☐ Diabetes	☐ Tetanus (lock jaw)	☐ Recent rapid weight loss
☐ Kidney Disease	☐ Recurrent Oral Lesions	

16. Please state any other medical condition not stated previously ____________________
    ____

17. Do you wear contacts? ☐ YES ☐ NO
    a) If yes, soft ☐ or hard ☐ lens and are you wearing them now? ____________________

FEMALES ONLY

18. Are you pregnant or do you think there is a possibility that you may be pregnant at this time? ☐ YES ☐ NO
19. Are you presently breast feeding? ☐ YES ☐ NO
20. Are you presently taking birth control pills? ☐ YES ☐ NO

GENERAL ANESTHESIA

1. Have you had anything to eat or drink, including water, since midnight? ☐ YES ☐ NO
    a) If yes, please state items, amounts, and time that you had them: ____________________
    ____
    b) If no, please state the last time you ate or drank: ____________________
    ____
2. IF YOU ARE BEING "PUT TO SLEEP" TODAY, WHO WILL BE DRIVING YOU HOME?
    Name: ____________________ Relationship: ____________________
3. Are they presently in the office? ☐ YES ☐ NO
    a) If no, please give phone number where they can be reached:
    ____

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I have read and understand the above information and hereby certify that the information given is correct and truthful to the best of my knowledge and has been reviewed with me by authorized personnel.

____________________ (PATIENT) ____________________ (DATE)

____________________ (WITNESS)