ROBERT E. CHRISTENSEN D.D.S.
JOHN K. DRISDALE D.M.D.

Patient Update Information Temp:_____

Patient's Name: _____DOB:_____Date:_____
ADDRESS:_____CITY_____STATE_____ZIP_____
HOME #:_____CELL #:_____WORK #:_____
SSN #: _____ DL #:_____
CAN WE TEXT AND EMAIL APPOINTMENT REMINDER? YES/NO
EMAIL ADDRESS_____

DENTAL INSURANCE INFORMATION: Has it changed? If yes, please update below

Subscriber Name: _____DOB: _____ SSN #:_____
Dental Insurance Company: _____Employer: _____
Group #_____ Member ID #_____

MEDICAL HISTORY – Are there any new changes?

List all medication you are currently taking (including all over the counter)

_____

_____

Please circle any of the Following medication you are ALLERGIC to:

Penicillin	Novocain	Codeine	Valium	Demerol	Morphine	Keflex
Erythromycin	Sulfa Drug	Carbocaine	Aspirin	Anesthetics	Tetracycline	Xylocaine

Other_____

Indicate which of the following you have had or have at the present. Circle "NO" or "YES" to each item

Mitral Valve Prolapse	NO/YES	Emphysema	NO/YES	Chemotherapy	NO/YES
Heart disease or Attack	NO/YES	Persistent Cough	NO/YES	Cancer or Tumors	NO/YES
Angina	NO/YES	Tuberculosis	NO/YES	Arthritis/rheumatism	NO/YES
High Blood Pressure	NO/YES	Asthma	NO/YES	Glaucoma	NO/YES
Low Blood Pressure	NO/YES	Hay Fever	NO/YES	Contact Lenses	NO/YES
Heart Murmur	NO/YES	Allergies or Hives	NO/YES	Hepatitis	NO/YES
Rheumatic Fever	NO/YES	Diabetes	NO/YES	Liver Disease	NO/YES
Congenital Heart Lesions	NO/YES	Stroke	NO/YES	A.I.D.S	NO/YES
Artificial Heart Valve	NO/YES	Venereal Disease	NO/YES	Blood Transfusion	NO/YES
Heart Pacemaker	NO/YES	Ulcers	NO/YES	Drug or Alcohol	NO/YES
Heart Surgery	NO/YES	Thyroid Disease	NO/YES	Frequent Headaches	NO/YES
Shortness of Breath	NO/YES	Epilepsy or Seizures	NO/YES	Psychiatric Care	NO/YES
Radiation Treatment	NO/YES	Artificial Joints	NO/YES	Blooding thinning medication	NO/YES
Latex Allergy	NO/YES	Past Infective Endocarditis	NO/YES	History of Bisphosphonates	NO/YES

Do you need to Pre-medicate for dental cleanings or treatment? Reason_____

If Female, are you: Pregnant or Breastfeeding NO/YES, if yes, due date:_____

COVID-19:

Have you tested positive for COVID NO/YES, if Yes When_____

Have you received the COVID- 19 Vaccine NO/YES, if yes When_____

Do you know any medical conditions disease not listed above that we should know about? NO/YES

Explain_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or if my medication changes, I will inform the doctor on or before my next appointment without fail.

_____

Patient's Signature Date