

Robert E. Christensen, D.D.S.
PATIENT INFORMATION UPDATE

Patient's Name: _____ DOB: _____ Date: _____

Mr. /Mrs. / Miss _____ Marital Status: Single/Married/Divorced/Separated/Widowed

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	Vibramycin	Novocain	Tylenol	Codeine	Valium
Erythromycin	Sulfa Drug	Carbocaine	Aspirin	Demerol	Barbiturates
Morphine	Tetracycline	Keflex	Xylocaine	Anesthetics	

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	Fen Phen	NO/YES	Frequent Headaches	NO/YES
Shortness of Breath	NO/YES	Artificial Joints	NO/YES	Psychiatric Care	NO/YES
Radiation Treatment	NO/YES	Epilepsy or Seizures	NO/YES	COVID-19	NO/YES
Latex Allergy	NO/YES	Thyroid Disease	NO/YES		

IF Female, are you: Pregnant NO/ YES, if yes _____ weeks Through Menopause NO/YES

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 medicine changes, I will inform that doctor on or before my next appointment without fail.

Patient's Signature

Date

Doctor's Signature

Date