Mansfield-IvyRose
2170 Matlock Rd Ste 100
Mansfield, TX 76063
Ph # : 682-518-5655
Fax # : 682-518-5679

IVY ROSE FAMILY DENTISTRY, PA

Patient Personal Information

Title		Nickname		Birth Date	Age
Last, First				Marital Status	Sex
Address				Home #	Work #
				Cell #	Drive Lic
City, State, Zip				Emergency Contact	Emergency Phone #
Email				Student	SSN
Health Care Guardian Name				School Name	
Health Care Guardian Phone #				Referral Type	

Person responsible/guarantor for paying bills

Title		Nickname		Birth Date	Age
Last, First				Marital Status	Sex
Address				Home #	Work #
				Cell #	Drive Lic
City, State, Zip				SSN	
Email					

Do you have Primary Dental Insurance? __ Yes __ No				Do you have Secondary Dental Insurance? __ Yes __ No			
Group No/Name				Group No/Name			
Insurance Name				Insurance Name			
Phone #				Phone #			
Employer Name				Employer Name			
Subscriber Last, First				Subscriber Last, First			
Subscriber Address				Subscriber Address			
City, State, Zip				City, State, Zip			
Relationship to Patient		Birth Date		Relationship to Patient		Birth Date	
Subscriber ID				Subscriber ID			

Patient Medical Information

Allergic To
- ☐ Y ☐ N Amoxicillin/Penicillin
- ☐ Y ☐ N Keflex
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Sulfa Drugs
- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Iodine
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Epinephrine
- ☐ Y ☐ N Other Allergies

Cancer
- ☐ Y ☐ N Type _____
- ☐ Y ☐ N Chemo/Radiation Therapy

Pre-medicate
- ☐ Y ☐ N Type _____
- ☐ Y ☐ N Herpes/Fever Blister

Cardiovascular
- ☐ Y ☐ N Angina (chest pain)
- ☐ Y ☐ N Artificial Heart Valve
- ☐ Y ☐ N Heart Conditions
- ☐ Y ☐ N Heart Attack
- ☐ Y ☐ N Heart Surgery/Stint
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Low Blood Pressure
- ☐ Y ☐ N Mitral Valve Prolapse
- ☐ Y ☐ N Pacemaker
- ☐ Y ☐ N Rheumatic Fever
- ☐ Y ☐ N Scarlet Fever
- ☐ Y ☐ N Stroke
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N High Cholesterol

Endocrinology
- ☐ Y ☐ N Liver Disease
- ☐ Y ☐ N Thyroid Disease
- ☐ Y ☐ N Gout
- ☐ Y ☐ N Sjogrens

Gastrointestinal
- ☐ Y ☐ N Ulcers (stomach)
- ☐ Y ☐ N Gastrointestinal Disease

Hematologic/Lymphatic
- ☐ Y ☐ N Anemia
- ☐ Y ☐ N Blood Disorders
- ☐ Y ☐ N Bruise Easily
- ☐ Y ☐ N Excessive Bleeding
- ☐ Y ☐ N Blood Thinner

Musculoskeletal
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Artificial Joints
- ☐ Y ☐ N Jaw Joint Pain
- ☐ Y ☐ N Depression
- ☐ Y ☐ N Dizziness
- ☐ Y ☐ N Drug/Alcohol Addiction
- ☐ Y ☐ N Fainting
- ☐ Y ☐ N Seizures/Epilepsy
- ☐ Y ☐ N Psychiatric Illness
- ☐ Y ☐ N Dementia/Alzheimers
- ☐ Y ☐ N Migraines
- ☐ Y ☐ N Anorexia/Bulimia

Respiratory
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Emphysema
- ☐ Y ☐ N Respiratory Problems
- ☐ Y ☐ N Sinus Problems
- ☐ Y ☐ N Sleep Apnea
- ☐ Y ☐ N Tuberculosis

Women

Viral Infections

- ☐ Y ☐ N AIDS
- ☐ Y ☐ N HIV
- ☐ Y ☐ N HPV
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Hepatitis A/B/C
- ☐ Y ☐ N Jaundice
- ☐ Y ☐ N Kidney Disease
- ☐ Y ☐ N Rheumatoid Arthritis
- ☐ Y ☐ N Osteoporosis

Neurological

- ☐ Y ☐ N Anxiety

Other

- ☐ Y ☐ N Currently Pregnant
- ☐ Y ☐ N Nursing
- ☐ Y ☐ N Taking Medications

Dental Questionnaire

Dental Questionnaire

Name of previous Dentist _____

Date of your last cleaning? _____

Are your teeth sensitive to hot, cold or sweets ? _____

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears? _____

Do you clench or grind your teeth ? _____

Have you ever had orthodontic treatment (braces) ? _____

Are you having any specific problems with your teeth, gums, or mouth at this time ? _____

Are you happy with your smile ? _____

Do you have difficulty in opening your mouth widely ? _____

What is the most important thing to you about your dental visit today ? _____

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list _____

Medical Questionnaire

Emergency Contact

Emergency contact name _____

Emergency contact phone _____

Emergency contact relationship to patient _____

Medical Questionnaire

Family Physician and phone number _____

Are you currently under care of a Physician ? _____

If Yes, what is the condition being treated ? _____

Have you had any serious illness, operation or been hospitalized within the past 5 years? _____

List any medication you are currently taking ? _____

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast) _____

Are you currently taking the diet control drug Fen-Phen ? _____

Do you use alcoholic beverages ? _____

Do you smoke or chew tobacco? _____

Any current/past use of recreational drugs? _____

Women Only

Are you on hormone replacement therapy ?	
Are you on birth control pills / fertility drugs ?	
Additional Comments	
Any Disease, Condition or Problem not Listed ? Please list	

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature **Date**