Midwest Holistic Dentistry
John W. Johnson, DDS

Smiths Mill Office Park
5121 Forest Drive, Suite A
New Albany, Ohio 43054
614.775.9300

Personal History

Patient's Name: _____

Name You Prefer We Call You? _____

Address: _____

City/State/Zip: _____

Birthday: _____ Soc. Sec. No.: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Employer: _____ Position: _____ Business Name: _____

Insurance Info

Name of Insured: _____ Relationship to Patient: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec. No.: _____ Insured Birth Date: _____

City/State/Zip: _____

Employer: _____

Address: _____

Address2: _____

City/State/Zip: _____

Rem. Benefits: _____ 00 Rem. Benefits: _____ 00

Ins. Company: _____

Address: _____

Address2: _____

City/State/Zip: _____

Phone: _____

Would you like a confirmation for your appointment? ◯ Yes ◯ No By ◯ Phone ◯ Fax ◯ Email

Whom may we thank for referring you? _____

Medical History

Height: _____ Weight: _____

Please answer "yes" or "no" to the following:

_____ Heart Condition
_____ Heart Murmor-Mitral Valve Prolapse
_____ Rheumatic Fever
_____ Stroke
_____ High/Low Blood Preassure
_____ Circulatory/Blood Disorders
_____ Diabetes
_____ Hepatitis/Liver Condition
_____ Cancer/Radiation Therapy

_____ Arthritis
_____ Ulcers
_____ Hemophilia
_____ Blood Transfusion Since 1980
_____ Emphysema
_____ Organic Obstructive Pulmonary Disease
_____ Asthma
_____ Sinus Condition
_____ Candida/Yeast Infection

Medical History Con't

_____ Psychiatric Care
_____ Nevous Condition
_____ Typhoid Fever
_____ Tuberculosis
_____ Pregnant
_____ Venereal Disease
_____ Herpes
_____ Alcohol Problems
_____ Arc-Aids

_____ Prosthetics/Artificial Joints
_____ Recreational Drug Use
_____ Self-Injection Drugs
_____ Chemically Sensitive
_____ Use Tobacco Products
_____ Drink Tea, Coffee, Soft Drinks, Red Wine
_____ History of Bulimea or Anorexia
_____ Other_____

If you have answered "yes" to any of the above, please give additional information such as present treatment and medicine:

Please list all medications and herbal supplements, including dosage and directions, you are taking:

List all known allergies to:

Medications: _____ Anesthetics: _____

Foods:_____ Other: _____

Describe type of reaction: _____

Family or present care physician: _____

Dental Health History

How long since your last dental visit?: _____

What was done then?: _____

How many times daily do you: Brush: _____ Floss: _____

Please check any of the following you are aware of:

_____ Gums Bleeding
_____ Unpleasant breath or taste
_____ Popping, clicking or snapping noises when you chew (TMJ)
_____ Grinding or clenching your teeth
_____ Headaches/How often?
_____ Earaches or ringing in your ears

_____ Used any teeth whitening products in the past
_____ Sensitivity to temperature, pressure or sweets
_____ Have fixed orthodontic appliance
_____ Have missing teeth (besides wisdom teeth)
_____ Had root canal (endodontic) therapy
_____ Any fillings in front teeth
_____ Discolored teeth due to trauma, endodontics
_____ Or result of antibiotics

Reason for visit: ◯ Routine Exam ◯ Specific Problem

Please Describe: _____

Do you have fears about dentistry? _____

How can we make you more comfortable? _____

How do you feel about your: Teeth: _____ Dentures: _____

For office use only
Reviewed by:
Date:

To the best of knowledge, the answers to all questions are correct as indicated. I release permission to the Doctor to use my photographs and/or diagnostic aids for his educational purposes.

X _____
Patient Signature(Parent if Minor) Date

Midwest Holistic Dentistry
John W. Johnson, DDS
Smiths Mill Office Park
5121 Forest Drive, Suite A
New Albany, Ohio 43054
614.775.9300

Cancellation Policy

In order to stay on time and provide the most comprehensive dental care for our patients, we request that you arrive 10 minutes early for your appointment to allow time for checking in.

If you arrive more than 15 minutes late, you will need to reschedule

If you are unable to keep an appointment, you must notify us two (2) business days in advance, so that we are able to see other patients.

If your dental appointment is on a Monday, you must call on Thursday before 12 pm to re-schedule or cancel the scheduled appointment to avoide a late cancellation fee of $150.00 (Our office is closed on Fridays)

No Show/Late Cancellation Policy:

1st-No show/late cancellation-patient will need to pay half of the scheduled appointment fee when scheduling the appointment.

2nd-No show/late cancellation fee-patient will need to pre-pay all future dental appointments.

3rd-No show/Late cancellation- patient will be dismissed from practice.