Midwest BioHealth
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.: _____

Best Phone#: (____) _____ email: _____

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:

Have you taken or are you currently taking osteoporosis drugs? ◯ Yes ◯ No

Have you taken or currently taking chemo therapy or biphosphonates? ◯ Yes ◯ No

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