Dr. Bruce M. Crawford
Implant Dentistry & Laser Periodontics

1. Nature of your dental problem ___________________________________________
2. Are you having pain or discomfort at this time? Where? ______________________ Y N
3. Are any of your teeth sensitive to hot, cold, sweet or sour? Where? ______________ Y N
4. Do you have sores in or around your mouth? Where? _________________________ Y N
5. Do your gums bleed? If so, when? ______________________________________ Y N
6. Have you ever had periodontal treatment? If yes,
   When? _________________________
   What? _________________________
   Where? _________________________
7. Do you have any breathe odor or unpleasant taste? ____________________________ Y N
8. Do you have loose teeth? Where? ______________________________________ Y N
9. Do you have any popping, grinding, locking or pain in either jaw joint? Y N
10. Has your dental care been regular? Y N
11. How long ago was your last dental cleaning? __ 3 mo __ 4 mo __ 6 mo __ Other ______
12. How often do you have your teeth cleaned? __ 3 mo __ 4 mo __ 6 mo __ Other ______
13. When was the last time you had dental x-rays taken? __ 6 mo __ 1 yr __ 5 yr __ Other ___
14. How many times a day do you brush your teeth? __ once __ twice __ three __ Other ____
15. Do you floss? Y N How often? __ Daily __ 2-3 x wk __ weekly __ Other _____
16. Do you have any removable dental appliances/partials/dentures? __________________ Y N
17. Have you ever had orthodontic treatment (braces)? When? _____________________ Y N
18. Do you smoke? Y N If yes, how much? ______________________________________
19. Have you smoked in the past? Y N Quite Date ____________________
20. Do you chew tobacco, use snuff or smoke cigars? Y N How often? ________________
21. Have you ever had serious problems with dental treatment? Y N
    Please explain ___________________________________________________________
    ________________________________________________________________________
22. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____________________________________________________
    ________________________________________________________________________

I certify that the above information is complete and accurate.

_________________________________________ ________________________
Patient Signature Date