Dr. Bruce M. Crawford
Implant Dentistry & Laser Periodontics

Best Appointment Day/Time _____ Date _____

Name _____ Date of Birth _____

Social Security # _____ Marital Status: S M D W Email _____

Phone: Home _____ Work _____ Cell _____

Home Address _____

City _____ State _____ Zip _____

Employer _____ Occupation _____

Work Address _____ City _____ ST _____ Zip _____

Dental Insurance Co _____ Soc Sec / Policy No _____

Policy in Name of _____ Date of Birth _____

Employer of Policy Holder _____ Group No _____

Referred by _____ General Dentist _____ Pharmacy & Phone _____

MEDICAL HISTORY

1. How is your general health at this time? _____
2. Do you have or have you ever had any of the following conditions?

( ) Joint Replacement Date _____	( ) Angina Pectoris	( ) Tuberculosis (TB)
( ) Heart Murmur	( ) Stroke Date _____	( ) Hepatitis A B C / Liver Disease
( ) Mitral Valve Prolapse	( ) Allergies	( ) Alcoholism / Drug Addiction
( ) Congenital Heart Disease	( ) Asthma	( ) HIV Positive
( ) Heart Valve Replace / Shunts	( ) Emphysema	( ) A.I.D.S.
( ) Rheumatic Fever Date _____	( ) Chronic Bronchitis	( ) Blood Disorders
( ) Pacemaker Date _____	( ) Arthritis / Rheumatism	( ) Anemia
( ) Heart Disease / Attack	( ) Glaucoma	( ) Cancer / Tumors / Radiation
( ) Heart Surgery Date _____	( ) Thyroid Disease	( ) Epilepsy / Seizures
( ) High Blood Pressure	( ) Kidney Disease	( ) Diabetes Type _____

3. Have you ever had any serious illness or operation? ___ Yes ___ No If yes, what and when: _____
   _____
4. Do you have tendency to prolonged bleeding following injury or surgery? ___ Yes ___ No
5. Do you take any blood thinners (anti-coagulants), aspirin, Vitamin E or Fish Oil? ___ Yes ___ No
6. Have you ever taken bone density medications? ___ Yes ___ No
7. Are you allergic to or have you reacted adversely to any drug or medicine? ___ Yes ___ No
   Please list and explain: _____
8. Please list any Prescription medications you are presently taking:
   _____ for _____ _____ for _____
   _____ for _____ _____ for _____
   _____ for _____ _____ for _____
9. Please list any over the counter medications, herbs and / or vitamins you are presently taking:
   _____
10. Do you have any medical condition not mentioned above? ___ Yes ___ No If yes, please explain:
    _____
11. Name of your Physician _____ Approx Date of last physical _____

Women Only: Are you pregnant? ___ Yes ___ No Expected delivery date _____

Do you take birth control pills? ___ Yes ___ No Have you reached Menopause? ___ Yes ___ No

Hygienist Updates: _____ _____ _____

_____ _____ _____