Southwest
Dental Associates

Helen H. Harless, D.D.S., F.A.G.D.

Dental History

Name _____ Birth Date ____/____/____

Date of last dental visit ____/____/____ Date of last dental X-rays ____/____/____

Reason for last visit? _____

Do you have any concerns about previous dental care or this dental visit? _____

_____

Do you gums bleed? Yes ☐ No ☐

Are your teeth loose? Yes ☐ No ☐

Have you even been told you have gum disease? Yes ☐ No ☐

Are you concerned about bad breath? Yes ☐ No ☐

Are your teeth sensitive to? Sweets ☐ Cold ☐ Heat ☐ Pressure ☐

Have you ever had any pain in your jaw joints (clicking, popping)? Yes ☐ No ☐

Are you happy with your smile? Yes ☐ No ☐

If No, explain _____

What would you change about the present condition of your mouth? _____

_____

Signature

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand that it is very important to report any changes or updates in my medical status. I give permission to obtain from my physician any additional information regarding my medical history needed to provide me with the best treatment possible.

Signed _____ Date _____

If you have completed this form for another person, please print your name and sign below along with your relationship to patient.

Print _____ Relationship _____

Signed _____ Date _____

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