Children's Dental Associates

of New London County, P.C.

190 Hempstead St
New London, CT 06320
860-447-3216

392 Salem Tpke (Rt82)
Bozrah, CT 06334
860-886-5576

35 Halls Hill Rd
Colchester, CT 06415
860-537-6655

131 Boston Post Rd
East Lyme, CT 06333
860-691-5014

925 Old Buddington Rd
Groton, CT 06340
860-448-2820

Patient Dental History

In order to assure your child's safety, comfort and happiness during dental treatment, we need to obtain information from you. Please read carefully and completely answer the questions below.
Thank you. Please Print:

Child's Name_____
First Middle Last

Date of Birth _____/_____/_____
Month Day Year

Dental History

Why did you make this appointment?_____

_____

_____

Is this your child's first visit to the dentist? YES NO
If not, how long since the last dental visit?_____

Child's previous dentist:
Name_____
Address_____
Approximate date of last dental "x-rays"____/_____
Month Year

Does your child currently have any dental problems or has your child ever had any major dental problems in the past? YES NO
If so, please explain:_____

_____

Has your child had any injury to the teeth, mouth or jaw? YES NO

Does your child have any jaw joint clicking, locking or pain? YES NO

Cavity Prevention History

Does your child receive fluoride daily? Check **one**
☐ we have fluoride in our water supply.
☐ we do not have fluoride in our water.
☐ child swallows a fluoride supplement daily.

Does your child
Use a toothpaste containing fluoride? YES NO
Use a fluoride mouthwash at home? YES NO
Receive a fluoride mouthwash at school? YES NO
How often are your child's teeth brushed?_____

Is your child familiar with dental floss? We use it:
☐ Daily ☐ Occasionally ☐ Never

Growth and Development History

Have you ever been advised that your child has a "bite problem?" YES NO
Does your child have any oral habits such as thumb, lip or finger sucking, pacifier,nailbiting, clenching or grinding teeth, etc? YES NO
Does your child have a speech problem of which you are aware? YES NO

How did you find out about our office?
☐ Physician ☐ Dentist ☐ Friend ☐ Phone Book ☐ Another child in the family is a patient ☐ Other_____

Who may we thank for referring you?_____

Address: _____

Date: ___/___/____PRV's initial_____