MEDICAL INFORMATION

Patient Name: _____ **Parent/Guardian:** _____

Phone Number: _____ **Parent/Guardian:** _____

Describe the nature of your child's disability:

Are they currently taking any medications? ☐ **Yes** ☐ **No**

If yes, what medications:

Has your child ever had seizures? ☐ **Yes** ☐ **No**

If YES, date of last seizure:

Describe the type of seizure:

Does your child have any allergies? ☐ Yes ☐ No

If yes, please list:

Does your child wear a hearing aid? ☐ Yes ☐ No

If YES, please explain:

Does your child have any other physical challenges that the dental team should be aware of?

Oral Care

Has your child visited the dentist before?	☐ **Yes**	☐ **No**
If yes, please describe:		

Please describe your child's at-home dental care:

Does your child use a powered toothbrush or a manual toothbrush?	☐ **Yes**	☐ **No**
Does your child floss?	☐ **Yes**	☐ **No**
Does your child brush independently or with parent/guardian's assistance?	☐ **Independent**	☐ **Assistance**

What are your dental health goals for your child?

How often does your child snack during the day and on what types of foods?

Communication & Behavior

Is your child able to communicate verbally?	☐ **Yes**	☐ No

Are there certain cues that might help the dental team?

Are there any useful phrases or words that work best with your child?

Does your child use non-verbal communication?	☐ **Yes**	☐ **No**

Please check any of the following that your child uses:	☐ **Mayer Johnson Symbols**	☐ **Sign Language**
	☐ **Picture Exchange Communication System (PECS)**	☐ **Sentence Board or Gestures**

Will you be bringing a communication system with you?	☐ **Yes**	☐ **No**

Are there any symbols/signs that we can have available to assist with communication?

Behavior/Emotions

Please list any specific behavioral challenges that you would like the dental team to be aware of:

Please feel free to bring objects that are comforting and/or pleasurable for your child to any dental visit.

Sensory Issues

Please list any specific sounds that your child is sensitive to:

Does your child prefer the quiet?	☐ **Yes**	☐ **No**
Is your child more comfortable in a dimly lit room?	☐ **Yes**	☐ **No**
Is your child sensitive to motion and moving (i.e., the dental chair moving up and down or to a reclining position)? **Please explain:**	☐ **Yes**	☐ **No**
Does your child have any specific oral sensitivities (gagging, gum sensitivities, etc.)? **Please explain:**	☐ **Yes**	☐ **No**
Do certain tastes bother your child? **If yes, please list below**	☐ **Yes**	☐ **No**
Is your child more comfortable in a clutter-free environment?	☐ **Yes**	☐ **No**

Please provide us with any additional information that may help us to prepare for a successful dental experience: