Getting to Know You

Patient name:

_____

Parent/guardian/caregiver name:

_____

Describe the patient's disability:

_____

_____

_____

Is the patient on a special diet? yes ___ no____
Type of foods patient likes to eat regularly:

_____

_____

Does the patient have any physical challenges that the team should be aware of? Example: In a wheelchair, delayed fine motor skills, uses a walker:

_____

_____

_____

Has the patient visited the dentist before?
yes____ no____
If yes, when was the last visit?: _____

Please describe the experience for both caregiver and patient: _____

_____

Describe the patient's at-home dental care:
How frequent does the patient brush?

_____

Does patient need brushing assistance?
yes ____ no ____
Manual toothbrush? yes ____ no____
Electric toothbrush yes ____ no ____
What flavor of toothpaste do they prefer?

_____

How frequent does the patient floss?

_____

Does the patient need flossing assistance?

_____

How often does the patient use mouthwash?

_____

Does the patient have any issues spitting?
yes ____ no____
Is fluoride/varnish ok to use on patient?
yes ____ no ____
Who aides the patient during their homecare routine?

_____

_____

Where is the brushing performed and in what position? Example: in bathroom/standing or in bedroom/lying on bed

_____

_____

_____

Does the patient have any challenges with brushing and flossing at home? yes ____ no ____ if yes, please describe:

_____

Can the patient communicate verbally?
yes____ no ____
If yes, is communication level age appropriate?
yes ____ no____
If no, what age level are they at? _____
Are there any certain cues that might help the dental team? Example: hands quiet, mouth quiet

_____

_____

Does the patient use non-verbal communication? yes ____no ____
If yes, please describe:

_____

_____

Getting to Know You

Is the patient currently receiving any form of therapy? Example: aba, ot/pt, speech therapy, etc:

_____

_____

_____

Are there any specific behavior challenges that dental team should be aware of?

Example: screaming, self-injury, aggressive towards others, meltdowns, inability to sit still

_____

_____

_____

What rewards are used to reinforce good behavior? Example: food, toys, games, movies:_____

_____

How is negative behavior redirected ?

_____

Are there any sounds the patient is sensitive to? Example: vacuums, dental suctions

_____

Does the patient prefer quiet?
yes ____ no ____

Is the patient more comfortable in a dimly lit room?
yes ____ no ____

Is the patient sensitive to motion and moving? Example: dental chair moving up and down or laying back?

yes ____ no ____

Does the patient have any specific oral issues? example: gagging, gum sensitivities, pica - eating nonfood objects, pouching of food, chewing or sucking on hands/fingers

_____

_____

Does the patient have any other triggers that the dental team should be aware of?

_____

_____

Do certain tastes/flavors bother the patient:
yes ____ no ____

If yes, please list:

_____

_____

What are your expectations for the patient's dental visit?

_____

_____

_____

Please list any fears or concerns the patient may have about the dentist:

_____

_____

_____

When necessary, we utilize different forms of behavior modification techniques to ensure the comfort and safety of the patient.
Please number in the order of your preference:
_____ Desensitization
_____ Protective medical stabilization
_____ Sedation (I.V.)