



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.)