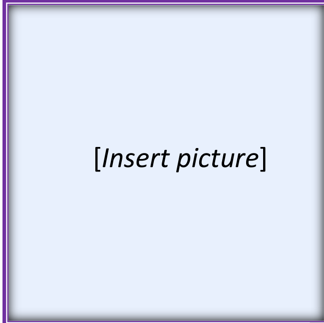
My Dental Care Passport

This is essential reading for all dental office staff working with me. It gives important information about how I can be better supported when visiting your clinic. This passport should be kept visible and used when you talk to me or have a question about me.

This form was completed with help from: ________________________ Phone: __________

ALL ABOUT ME



[*Insert picture*]

My name is: Click or tap here to enter text.

I like to be called: *(nick name if you have one)*

Click or tap here to enter text.

I am: ☐Male ☐Female ☐ Something else

My preferred gender pronoun is:

☐ He ☐ She ☐ They ☐ Ze ☐ Not listed ☐ No preference

Where I live right now: *(For example - supported living or my family home.)*

Click or tap here to enter text.

What type of disability/ies I have:

Primary: Click or tap here to enter text.

Secondary: Click or tap here to enter text.

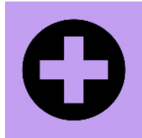
This is the best person to contact for more information about me or if I need help: *(Please list name, role, and contact phone number.)*

Click or tap here to enter text.

Other key professionals involved in my care that might be helpful to contact: *(Please list name, role, and contact phone number.)*

Click or tap here to enter text.

DRAFT



MEDICAL HISTORY

My brief medical history: *(include other conditions such as visual impairment, hearing impairment, diabetes, epilepsy, asthma, depression as well as past serious illnesses or operations, and other medical issues)*

Click or tap here to enter text.

These are the medicines I take now and how they help me: *(Please list all prescription and non-prescription medications)*

Click or tap here to enter text.

I have bad reactions when I take these medicines: *(Please list drugs that you are allergic to or do not tolerate well, including details on what reactions would be.)*

Click or tap here to enter text.

I am allergic to latex: ☐ YES ☐ NO

DENTAL HISTORY

My last visit to a dental office was: (*circle one)*

☐ Within the last 3 months ☐ 6 months ☐ 1 year ☐ Over a year ago ☐ Never

When I had dental care in the past, I needed special medicine to help me stay calm (*hospital setting, I.V. Sedation, nitrous oxide/gas)* ☐ YES ☐ NO

If yes, describe what was used, if known.

Click or tap here to enter text.

How I react to dental or medical procedures: *(For example- usual response to shots, IV's, examinations, x-rays)*

Click or tap here to enter text.

My best visit to the dental office is when: (*Share things that DID work well)*

Click or tap here to enter text.

My worst visit to the dental office is when: *(Share things that DID NOT work well)*

Click or tap here to enter text.

Here are the questions and/or worries I have about my teeth and mouth:

Click or tap here to enter text.

These are the things I or my helper do every day to take care of my teeth:

Click or tap here to enter text.

It is hard for me to care for my teeth ☐ YES ☐ NO

If yes, please explain: Click or tap here to enter text.

These are the things I need to be comfortable in a dental chair: *(please check all that apply)*

Support for: ☐ neck ☐ back ☐ arms ☐ knees ☐ feet

☐ Sit up in dental chair (cannot tolerate a reclined position)

☐ Supportive stabilization security wrap

☐ Stabilization support for spasms

I do better when dental staff provide my care:

☐ From behind me ☐ In front of me ☐ Does not matter

If I start to choke, here is how you can help:

Click or tap here to enter text.

MOBILITY

I use these aids to help me move:

Click or tap here to enter text.

You can help me move by: (assistance needed to get into dental chair, go to the restroom)

Click or tap here to enter text.

COMMUNICATION & BEHAVIOR

Ways that I prefer to communicate with people:

☐ Talk to me directly

☐ Give me time to process the questions

☐ I have a speech impairment and can be difficult to understand

☐ It takes time to form my words so please be patient

☐ Click or tap here to enter text.

I communicate using: (*For example- speech, preferred language, sign language, communication devices or aids, pictures, non-verbal sounds, also state if extra time/ support is needed)*

Here are the ways I communicate some things:

Worried/scared/angry: Click or tap here to enter text.

Yes/Okay/ I understand: Click or tap here to enter text.

No/ I do not understand: Click or tap here to enter text.

Other: Click or tap here to enter text.

On most days, I would describe myself as: *(select all that apply)*

☐ Happy ☐ Quiet ☐ Nervous

☐ Sleepy ☐ Loud ☐ Angry

These are the things I do sometimes that may be hard or dangerous: *(For example- uncontrolled arm movements that may strike your hand when holding a dental tool)*

Click or tap here to enter text.

These are some things that can help me relax: *(check all that apply)*

☐ Earphones to block out noise

☐ Eye covers to block light and activities

☐ Security blanket/stuffed animal to hold

☐ Click or tap here to enter text.

SENSITIVITIES

These are some things that can upset me: *(select all that apply)*

☐ Smell – office, perfume, cologne
☐ Sounds – music, drill, phones, voices, clock
☐ Sight – lights, overhead arm, mirrors, shiny tools
☐ Positions – chair height and tilt, being “still”, lying flat
☐ Closeness – people, water, light, x-ray machine
☐ Touch/Temp –gloves, air, gauze, water, suction, room/water temperature, toothbrushing
☐ Texture – toothpaste, gauze, cotton, metal
☐ Pressure – seeking or aversion
☐ Taste – gloves, toothpaste, fluoride

OTHER THINGS YOU MIGHT NEED TO KNOW ABOUT ME

(Please use this space for any further information)

Click or tap here to enter text.