Dental Visit Information

Patient Information:

Patient's Name:	
Nickname:	
Parent/Guardian:	
Phone Number:	
Cell Number:	

Please describe the individual's disability or physical challenges:	
Has individual been diagnosed with a sensory processing issue?	☐ Yes ☐ No
Does the individual have vision impairment? **If *yes* , please explain:**	☐ Yes ☐ No
Does individual wear hearing aids?	☐ No ☐ Bilaterally ☐ Left ☐ Right
Does individual have any physical challenges the dental team needs to be aware of?	☐ Yes ☐ No
Is individual able to speak and communicate with dental team? ***If no or limited*, does individual communicate via:**	☐ Yes ☐ No ☐ Limited ☐ Sign Language ☐ Sentence Board ☐ Exchange System ☐ Other
Will individual have communication system available during appointments?	☐ Yes ☐ No ☐ N/A
Are there any phrases or words that are useful for the dental team to use?	
Are there any clues or information that would help the dental team?	

Dental Visit Information

Are there any behavioral challenges the dental team should be aware of?	
Has the individual been to a dental appointment before? ***Outcome:***	☐ Yes ☐ No
Approximate date of last dental visit? / /	
Dental services performed at that visit?	
Individual strengths:	
Is there a favorite item the individual will bring to the dental office that will make them more comfortable?	☐ Yes ☐ No
Are there things that may bother the individual in the dental office? **Please explain:**	☐ Yes ☐ No

Home Oral Health Care

Does the individual:

Brush their teeth independently?	☐ Yes ☐ No
Is a battery operated toothbrush used?	☐ Yes ☐ No
Floss?	☐ Yes ☐ No
Use a floss aid?	☐ Yes ☐ No

Signature **Date**