Questionnaire For Parents Of Patients With Special Needs

Patient's Name _____ Date _____

In order for us to better serve your child/loved one/legally dependent, we would appreciate your cooperation in completing this questionnaire. There may be some duplicate questions that coincide with our general health history or dental history forms; if the answer is extensive, please make a note that refers our office to the correct form.

1. What is the patient's diagnosed medical condition(s)?

2. When was this condition first diagnosed/discovered?

3. If the patient sees a specialist(s) for this condition, please list their names and phone numbers:

Doctor's Name:
Specialty:
Phone Number:

Doctor's Name:
Specialty:
Phone Number:

4. What is the patient's approximate developmental age?

5. At what level does the patient communicate verbally?

___Normally (no delay) ___Mild delay ___Moderate delay ___Does not speak

6. Has your patient's physician told you that your he/she needs to be pre-medicated (antibiotic coverage) before dental services can be provided? _____ No _____ Yes
If yes, confirm that the physician's name and office number are listed in question #3.

7. Does the patient have any allergies to medicines, blood disorders, or heart problems?
If so, please explain:

8. Has the patient had any negative dental experiences? _____No _____Yes (please explain)

9. Is there anything we should avoid doing or saying? (certain sounds, bright lights, touch?)

10. What does the patient like to do? Hobbies, favorite foods, etc.

11. Anything else you would like us to know?

Person filling out the form: _____ Relationship_____