DENTAL ASSOCIATES OF WALPOLE

Family ◦ Specialty ◦ Care

Supplemental Information for patients with Developmental and/or Physical Disability

Date of Initial Visit: _____

Patient's Name: _____ D.O.B:_____

Please leave this section for Dental Personnel use:

Guardianship Papers in patient's chart? Yes ☐ No ☐

No guardianship papers needed patient is not 18 years or older: ☐

Who is the guardian to the patient? _____ Relationship to patient: _____

Guardians Contact Number: _____

Is the patient at a group home? Yes ☐ No ☐ If yes, where? _____

Is the patient in a wheelchair? Yes ☐ No ☐

Can the patient be transferred into the patient chair? Yes ☐ No ☐

COMMUNICATION AND BEHAVIOR

Is the patient able to communicate verbally? Yes ☐ No ☐

Are there certain cues that might help the dental team? Yes ☐ No ☐

If yes, please explain:

_____

Are there any useful phrases or words that work best for the patient? Yes ☐ No ☐

If yes, what are those phrases or words?

_____

Does the patient use non-verbal communication? Yes ☐ No ☐

Will you bring a communication system with you? Yes ☐ No ☐

Are there any symbols/signs that we can have available to assist with communication? Yes ☐ No ☐

If yes, what are those symbols/signs?

_____

If we introduced pictures or visual diagrams to the patient about the different steps of the appointment, do you think he/she would benefit from that? Yes ☐ No ☐

BEHAVIOR AND EMOTIONS

Does the patient respond better to verbal praise or a reward after each step that he/she is introduced to? Yes ☐ No ☐

Are there any specific behavioral challenges that you would like the dental team to be aware of?

Yes ☐ No ☐

If yes, please explain:

_____

SENSORY ISSUES

Is the patient sensitive to loud noises? Yes ☐ No ☐

If yes, what are those specific sounds that he/she is sensitive to?

_____

Does the patient prefer a quiet setting? Yes ☐ No ☐

Is the patient sensitive to motion? (i.e., the dental chair moving up and down or to a reclining position)?

Yes ☐ No ☐

If yes, please explain:

_____

Does the patient have any specific oral sensitives (gagging, gum sensitivities, etc.)? Yes ☐ No ☐

If yes, please explain:

_____

Do certain tastes bother the patient? Yes ☐ No ☐

If yes, what are those tastes?

_____

Please provide us with any additional information that may help us prepare for a successful dental experience?

_____

_____