Questionnaire For Parents Of Patients With Special Needs

Child’s Name ____________________________ Date ________________

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

1. What is your child’s diagnosed medical condition(s)?

2. When was this condition first diagnosed/discovered?

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

<table>
<thead>
<tr>
<th>Doctor’s Name</th>
<th>Specialty Field</th>
<th>Phone Number</th>
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4. What is your child’s approximate developmental age?

5. At what level does your child communicate verbally?

   ___ Normally (no delay)   ___ Mild delay   ___ Moderate delay   ___ Does not speak

6. Has your child’s physician told you that your child needs to be premedicated (antibiotic coverage) before dental services can be provided? If yes, confirm that your child’s physician’s name and office number are listed in question #3.

7. Does your child have any allergies to medicines, blood disorders, or heart problems? If so, please explain.

8. Is this your child’s first visit to a dentist? _____ No _____ Yes

9. Has your child had any negative dental experiences? _____ No _____ Yes (please explain)

10. What does your child like to do? Hobbies, favorite foods, etc.

11. Anything else you would like us to know?