"Your Child's Care is Our Focus!"

Patient's Name: ______________________

For Autistic Children:

Please help us get to know your child better by answering the following questions:

1. When was your child first diagnosed? ____________________________________
2. Does your child see a specialist or therapist? - list their names and phone numbers

   ____

   ____
3. What is your child's approximate developmental age in years? ________________
4. Was your child toilet trained by age 4? ____________________________________
5. Is your child able to sit for a hair cut? ____________________________________
6. At what level does your child communicate verbally?

   ☐ Normal (no delay) ☐ Mild delay ☐ Moderate delay ☐ Does not speak
7. Does your child have specific sensitivities, such as sound, touch, light? – list

   ____
8. Is your child taking any medications? – list name, dose and reason

   ____
9. Is this your child's first visit to the dentist? _________________________________
10. Has your child had any negative dental experiences? – explain

    ____
11. Is there anything that comforts your child such as music, weighted blanket, textures?

    ____
12. Do you use a boardmaker for communication? ______________________________
13. Anything else you would like us to know?

    ____

I, the undersigned, verify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I consent to my physician being contacted if necessary to obtain information that is required for my child's dental care. I authorize the dentist to perform the diagnostic procedures that may be required to determine the necessary treatment and assume financial responsibility for dental services rendered for my child.

Parent/Guardian signature: ___________________________ Date: _______________

Reviewed by the dentist: ___________________________ Date: _______________

Dr. Anita B Gartner Inc. *Certified Specialist in Pediatric Dentistry*

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