



"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: _____