JOSEPH G. MIRCI
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Patient Information Questionnaire

Adapted from "Autism Speaks: Treating Children with Autism Spectrum Disorders: Dental Tool Kit for Families

Patient Information

Today's Date _____

Patient Name: _____ Parent/Guardian: _____

Phone Number: _____ Parent/Guardian: _____

Medical History

Describe the nature of your child's disability: _____

_____

Are they currently taking any medications, vitamins, herbal, and mineral supplements?

☐ No ☐ Yes (If yes, please list) _____

Has your child ever had seizures? ☐ No ☐ Yes

Date of last seizure: _____ Type of seizure: _____

Does your child have any allergies? ☐ No ☐ Yes (If yes, please list) _____

Does your child wear a hearing aid? ☐ No ☐ Yes (If yes, please explain) _____

Does your child have any other physical challenges that the dental team should be aware of? _____

_____

Oral Care

Has your child visited the dentist before? ☐ No ☐ Yes (If yes, please list date) _____

Please describe your child's at home dental routine: _____

_____

Does your child use an ☐ electronic or ☐ manual toothbrush

Does your child floss? ☐ No ☐ Yes

Does your child need assistance when brushing their teeth? ☐ No ☐ Yes

What are your dental health goals for your child? _____

_____

How often does your child eat during the day? ☐ 3 meals a day ☐ snacks between meals ☐ eats only when hungry

What types of foods? _____

Does your child drink soda? ☐ No ☐ Yes

Does your child drink fruit juice? ☐ No ☐ Yes

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Communication & Behavior

Is your child able to communicate verbally? ☐No ☐Yes
Are there certain visual or verbal cues that might help the dental team? (If yes, please explain)

_____

Are there any useful phrases or words that work best with your child? (If yes, please describe)

_____

Does your child use non-verbal communication? ☐No ☐Yes (If yes, please explain)

_____

Will you be bringing a communication system with you? ☐No ☐Yes (If yes, please explain)

_____

Will you be bringing visual supports to help your child during the visit? (If yes, please explain)

_____

If not, are there any supports that we can have available to assist with communication? (If yes, please explain)

_____

Behavior / Emotions

Please list any specific behavioral challenges that you would like the dental team to be aware of: _____

_____

Feel free to bring motivating items that are comforting and/or pleasurable for your child to the dental visit.

Sensory Issues

Please list any specific sounds that your child is sensitive to:
Does your child prefer the quiet? ☐No ☐Yes
Is your child more comfortable in a dimly lit room? ☐No ☐Yes
Is your child sensitive to motion and moving (i.e., the dental chair moving up and down or the a reclining position?)
☐No ☐Yes (If yes, please explain) _____
Does your child have any oral sensitivity (gagging, gum sensitivities, grinding, clenching, etc.)? ☐No ☐Yes
Do certain tastes bother your child? ☐No ☐Yes (If yes, please explain) _____
Is your child more comfortable in a clutter-free environment? ☐No ☐Yes (If yes, please explain)

_____

What frightens your child? _____
What calms your child? _____
Please provide your dentist with any additional information that may help prepare for successful oral health care.