



QUESTIONNAIRE FOR PARENTS OF PATIENTS WITH SPECIAL HEALTHCARE 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), please list their names and phone numbers:

Doctor's Name	Specialty Field	Phone #
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4) Birthday: _____ What is your child's exact age in years and months? _____ years _____ months

5) What is your child's approximate developmental age? _____ years

6) At what level does your child communicate verbally?

normally (no delay) mild delay moderate delay does not speak

7) Is your child receiving medication and, if so, which medications is your child currently taking, and the dosage?

No medicines Yes (please list info)

8) Has your child's physician told you that your child needs to be premedicated (antibiotic coverage) before dental services can be provided? No Yes

(If "yes", please confirm that your child's pediatric cardiologist's name and office number are listed in Question 3)

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

10) Is this your child's first visit to a dentist? No Yes

11) Has your child had any negative dental experiences and, if so, please describe? No Yes

12) What does your child like to do? Hobbies, favorite foods, etc.? _____

12) Anything else you would like us to know? _____