CAMBERWELL CHILDREN'S DENTISTRY

SPECIALIST PAEDIATRIC DENTISTS

Dr Jane Lee
BDS, DCD, FADI
Provider No: 254155BK

Dr Debra Elsby
BDS, MFDS, DCD
Provider No: 4234545H

Dr Margarita Silva
CD, MS, FICD
Provider No: 0505962L

& Associates

Date: ……

Patient Name: ……

Parent/Guardian Names: ……

MEDICAL HISTORY

Describe the nature of your child's autism:

Are they currently taking any medications, vitamins, herbal, and mineral supplements? Y / N
(If yes, please list: ……)
Has your child ever had seizures? Y / N
Date of last seizure: …….. Type of seizure: ……..
Does your child have any allergies? Y / N (If yes, please list: ……..)
Does your child wear a hearing aid? Y / N (If yes, please explain: ……)
Does your child have any other physical challenges that the dental team should be aware of? Y / N

ORAL CARE

Has your child visited the dentist before? Y / N (If yes, please list date: ……..)

Please share any details regarding previous visit/s:

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

Does your child use an electric or manual toothbrush? ……
Does your child floss? Y / N
Does your child need assistance when brushing their teeth? Y / N
What are your dental health goals for your child?

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

What type of foods?

Does your child drink soft drinks? Y / N Does your child drink fruit juice? Y / N

COMMUNICATION & BEHAVIOUR

Is your child able to communicate verbally? Y / N
Are there visual or verbal cues that might help us? Y / N If yes, please explain:

Are there any useful phrases or words that work best with your child? Please describe:

Does your child use non-verbal communication? Y / N If yes, please explain:

Will you be bringing a communication system with you? Y / N If yes, please explain:

Will you be bringing visual supports to help your child during the visit? Y / N If yes, please explain:

If not, are there any supports that we can have available to assist with communication? Y / N
If yes, please explain:

BEHAVIOUR/EMOTIONS

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

Please feel free to bring a familiar/favourite item that may aid in creating a positive dental visit for your child.

SENSORY ISSUES

Please list any specific sounds that your child is sensitive to:

Does your child prefer the quiet? Y / N
Is your child more comfortable in a dimly lit room? Y / N
Is your child sensitive to motion and moving (i.e. the dental chair moving up and down or to a reclining position)?
Y / N If yes, please explain:

Does your child have any oral sensitivity (gagging, gum sensitivities, grinding, clenching, etc.)? Y / N
Do certain tastes bother your child? Y / N If yes, please explain:

Is your child more comfortable in a clutter-free environment? Y / N If yes, please explain:

What frightens your child?

What calms your child?

Please provide your dentist with any additional information that may help prepare everyone for a successful visit:

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