Gary D. Sabbadini, D.D.S., A.P.C.

Dentistry for Children & Young Adults

Diplomate, American Board of Pediatric Dentistry
Fellow, American Academy of Pediatric Dentistry
Fellow, International College of Dentists
Fellow, Pierre Fauchard Academy

Dental Intake Form: Autism

Patient Name: _____ Parent/Guardian _____
Phone Number: _____ Parent/Guardian _____

Medical Information
Describe the nature of your child's disability:
Is he/she currently taking any medication? ☐ Yes ☐ No If yes, what medications:
Has your child ever had seizures? ☐ Yes ☐ No If yes, date of last seizure: Describe the type of seizure:
Does your child have any allergies? ☐ Yes ☐ No If yes, please list:
Does your child wear a hearing aid? ☐ Yes ☐ No If yes, please explain:
Does your child have any other physical challenges of which the dental team should be aware?

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Oral Care

Has your child visited the dentist before? ☐ Yes ☐ No
If yes, please describe:

Has your child had dental treatment before? ☐ Yes ☐ No
If yes, please describe:

Has your child had dental x-rays before? ☐ Yes ☐ No

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

What type of toothbrush does your child use?

Does your child floss? ☐ Yes ☐ No

How does your child brush? ☐ Independently ☐ With Assistance

What are your dental health goals for your child?

How often does your child snack during the day and on what types of foods?

Communication & Behavior

Is your child able to communicate verbally? ☐ Yes ☐ No

Are there certain cues that might help the dental team?

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

Does your child use non-verbal communication? ☐ Yes ☐ No

Please check any of the following that your child uses: ☐ Mayer Johnson Symbols ☐ Sign Language
☐ Sentence Board or Gestures ☐ Picture Exchange Communication System

Will you be bringing a communication system with you? ☐ Yes ☐ No

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Behavior/Emotions
Please list any specific behavioral challenges of which you would like the dental team to be aware:

Please feel free to bring objects that are comforting and/or pleasurable for your child to any dental visit

Sensory Issues
Please list any specific sounds to which your child is sensitive:
Does your child prefer the quiet? ☐ Yes ☐ No
Is your child more comfortable in a dimly lit room? ☐ Yes ☐ No
Is your child sensitive to motion and moving (i.e. the dental chair moving up and down or to a reclining position? ☐ Yes ☐ No Please explain:
Does your child have any specific oral sensitivities (gagging, taste, etc.)? ☐ Yes ☐ No Please explain:
Is your child more comfortable in a clutter-free environment? ☐ Yes ☐ No
Please provide us with any additional information that may help us to prepare for a successful dental experience: