SOCIAL AND BEHAVIORAL INTAKE RECORD: INITIAL DENTAL EXAMINATION

To the individual responsible for the below-named patient (ie. Legal guardian, nurse manager, administrator, etc.) and for completing this form: **Please note that this form is *not* meant to replace medical history information.** In order to prepare for and assure that the dental care provided to the patient most appropriately meets his or her needs, we would appreciate your completing this form. If you have any questions, please contact us at (*phone number of facility*).

PATIENT INFORMATION:

Name: _____ DOB: _____

Address:_____

Patient resides in: Family ❒ Foster care ❒ Community residence (e.g. ICF) ❒

CONTACT INFORMATION**:**

Contact Person:	Phone:	Fax:
Day Program:	Phone:	Fax:
Legal Guardian:	Phone:	Fax:

PATIENT DESCRIPTION:

	YES	NO		YES	NO
Verbal?			Sign Language ?		
Communication Device?			Arm Contractures?		
Understands simple commands?			Leg Contractures?		
Ambulatory?			Glasses?		
Wheelchair?			Dentures?		
Walker?			Hearing Aid?		
Swallowing Disorder? (Describe below)			Severe Gag Reflex?		
Needs physical support for dental chair?			Prosthesis? (Describe below) *		
Requires assistance to dental chair?			Seizures? (Describe below) *		
Cerebral Shunt?			PICA (Ingesting uneatables) (describe)		
SIB (Self-Abusive Behavior) (describe)					
Communicates: Effectively ❒ Fairly ❒ Poorly ❒			Weight: _____ lbs.		

NUTRITION

	YES	NO		YES	NO
Tolerates foods that require chewing?			Tolerates soft or pureed foods only?		
Feeding-tube?					
Use number to rate most often (5) to least often (1) liquid consumed.			Water __ Juice __ Milk __ Soda __ Coffee/Tea __		

PATIENT'S ORAL HEALTH

Please rate patient's oral health:	Good ❒ Fair ❒ Poor ❒ Not sure ❒
Do you suspect that patient has mouth pain or discomfort?	Yes ❒ No ❒ Not sure ❒
Teeth are brushed:	a.m. ❒ p.m. ❒ Other times ❒
Patient's response is daily oral hygiene:	Cooperative ❒ Some resistance ❒ Very resistant ❒ Not sure ❒
What is used for oral hygiene check all that apply:	Tooth brush Water pick Cloth or sponge ❒ Other tool ❒ (describe):

DENTAL CARE HISTORY

Visit types (check all that apply):	Examination Treatment Cleaning
Generally, patient's response is (check all that apply):	Cooperative Some resistance Very resistant Not sure
Last dental visit:	Date: Not Sure: Not known Location: _____
Has sedation been used for dental care (Check all that apply)?	Oral IM IV General anesthesia ❒
If general anesthesia, please provide date and location of most recent procedure.	Date: Address:
Are physical restraints used to provide patient management for dental care?	Describe:

INITIAL APPOINTMENT ASSESSMENT: COMPLETED BY DENTAL CARE TEAM

Behaviors: (Check all that apply)	Cooperative Resists contact Combative / aggressive Hyperactive Tremors Vocal outbursts
Primary language:	English Spanish Sign Other:
Approaches that work best with patient:	Calm Upbeat Humor Other :
Learning Style:	Tell me Show me Other (describe):
Describe what relaxes patient:	
Patient response will be helped with:	Touch: Soft Medium Firm No touch/ limited
	Sound: Low Medium Loud
	Light: Soft Normal
	Staff: Male Female Favorite staff member:
Patient likes as rewards:	Food or drink: Prize: Verbal praise Other (describe)
Please provide additional information that you feel would be helpful: For example: best time of day for visit, chair position for patient, patient's attention span, what relaxes patient (e.g. music etc) Please use this space to offer any additional information regarding above questions:	

Person completing this form: _____ Date: _____

Relationship to patient or title: _____