CP Rochester Family Dental Center

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 585-402-7448. Thank You.

Name:	DOB:	Age:

PATIENT DESCRIPTION:

	YES	NO		YES	NO
Verbal?	☐	☐	Sign Language?	☐	☐
Communication Device?	☐	☐	Arm Contractures?	☐	☐
Ambulatory?	☐	☐	Leg Contractures?	☐	☐
Wheelchair?	☐	☐	Glasses?	☐	☐
Walker?	☐	☐	Dentures?	☐	☐
Swallowing Disorder? (Describe below) *	☐	☐	Hearing Aid?	☐	☐
Needs physical support for dental chair?	☐	☐	Severe Gag Reflex?	☐	☐
Requires assistance to dental chair ?	☐	☐	Prosthesis? (Describe below) *	☐	☐
Cerebral Shunt?	☐	☐	Seizures? (Describe below) *	☐	☐

Descriptions:

Communicates: Effectively ☐ Fairly ☐ Poorly ☐ Weight:

Speech: Verbal ☐ Non Verbal ☐ Hearing: Normal ☐ Impaired ☐ Deaf ☐

Vision: Normal ☐ Impaired ☐ Blind ☐

Other:

Name:_____

DOB:_____

Oral Health	YES	NO	Unknown
Do you suspect that patient has mouth pain or discomfort?	☐	☐	☐
Medication to reduce anxiety before Dental Appointment used: (Describe)	☐	☐	☐
Treatment in the Operating Room (has the patient received dental treatment while under general anesthesia: (Date)	☐	☐	☐
Adaptive equipment for oral hygiene used?	☐	☐	☐
Physical restraints used: (Describe)	☐	☐	☐

Dental Care History	
Visit type:	New Patient ☐ Examination ☐ Treatment ☐ Emergency ☐
Generally, patient's response is:	Cooperative ☐ Some resistance ☐ Very resistant ☐ Not sure ☐
Please rate patient's oral health:	Good ☐ Fair ☐ Poor ☐ Not sure ☐
Teeth are brushed:	a.m. ☐ p.m. ☐
	Other
Last dental visit:	Date: Not Sure: ☐
Previous Dentist:	
Brushing teeth and gums is:	Easy ☐ Somewhat difficult ☐ Very difficult ☐ Not sure ☐

Nutrition	YES	NO		YES	NO
Tolerates all foods?	☐	☐	Tolerates soft or pureed foods only?	☐	☐
Feeding-tube?	☐	☐			

Check all that apply and circle the most frequently used liquid:

Water ☐ Juice ☐ Milk ☐ Soda ☐ Coffee/Tea ☐

Name:_____

DOB:_____

INITIAL APPOINTMENT ASSESSMENT:

Behaviors: (Check all that apply)	Cooperative ☐ Resists contact ☐ Combative / aggressive ☐ Hyperactive ☐ Tremors ☐ Vocal outbursts ☐ Pica ☐	
SIB?:	Describe:	
Primary language:	English ☐ Spanish ☐ Sign ☐	
	Other:	
Approaches that work best with patient:	Calm ☐ Upbeat ☐ Humor ☐	
	Other:	
Learning Style:	Tell me ☐ Show me ☐	
	Other:	
Techniques that relax patient:		
Type of music patient enjoys:		
Patient responds best to:	**Touch:** Soft ☐ Medium ☐ Firm ☐ No touch / limited ☐	
	Sound: Low ☐ Medium ☐ Loud ☐	
	Light: Soft ☐ Normal ☐	
Favorite staff member:	**Staff Preference:** Male ☐ Female ☐ :	
Strong Reinforcers (Coffee, stickers):		
Optimal positioning in dental chair:		
Recommendations for first appointment:	Physical environment:	

Does the patient respond to simple directions?
Describe general attention span:
What is needed to create a positive experience for the patient?

Person Completing Form:_____ Date:_____

Relationship to the Patient or Title:_____