Fara Bender, DMD **Pediatric Dentistry**

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QUESTIONNAIRE FOR PARENTS OF SPECIAL PATIENTS

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) for this condition, please list their names and phone numbers:

Doctor's Name	*Specialty Field*	*Phone #*

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 for the condition 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 premeditated (antibiotic coverage) before dental services can be provided? ____*NO* ____*YES (if "yes", 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.?