

Pre-Treatment Assessment Form Part I To Be Completed by Parent or Caregiver

Today's Date: _____

Patient's Name: _____

Patient's DOB: _____

Sibling Order _____

Diagnosis: _____

Previous Dental Experiences: _____

Parent or Caregiver: _____

The Patient needs (Check Whichever Apply):

_____ Routine Exam

_____ A Filling

_____ A Cleaning

_____ "A Lot of Work"

_____ Orthodontic Treatment

_____ An Extraction

_____ Not Sure, but seems to be in pain

_____ Don't Know

The Patient's level of cooperation is likely to be:

_____ Age Appropriate

_____ Playful

_____ Non-Focused

_____ Wiggly

_____ Aggressive

_____ Short Attention Span

_____ Combative

_____ Don't Know

Management Techniques I Would Like the Doctor to Use:

_____ Sedation

_____ Short, Multiple Visits

_____ Restraint

_____ Operating Room/General Anesthesia

_____ Don't Know

Regarding whether you stay with the Patient or wait in the Waiting Room, please circle if you Agree or Disagree with the following:

It is best if I stay with the Patient because the Patient needs me to be there.

Agree/Disagree

It is best if I stay with the Patient because I can help the Doctor and the Staff.

Agree/Disagree

It is best if I stay with the Patient because I need to be there.

Agree/Disagree

It is best if I wait in the Waiting Room because Dentists make me nervous, and that won't help the situation.

Agree/Disagree

It is best if I wait in the Waiting Room because the Doctor knows best how to handle the Patient's behavior in the dental environment.

Agree/Disagree

Things that I know will motivate the Patient to try harder (e.g. computer time, DVD, ice cream, etc.).

Any other information that the Staff should know prior to working with this Patient.
