Kidz-Teeth
SPECIALIST PAEDIATRIC DENTISTS

Understanding your child

We appreciate the trust you place in our team to support your child's dental health. To help us make your child's visit as comfortable and positive aspossible, any background information you can provide in advance will be greatly appreciated.

Full Name:_____

Date of Birth:_____ **Age:**_____ ☐ **Female:** ☐ **Male:** ☐ **Other:**

E-mail:_____

Mobile:_____

Parent / Guardian Names:_____

1. Does your child have any sensory aversions?

2. Does your child have any sensory seeking behaviours?

3. Are there any rewards or reinforcers that work for your child?

4. Is there anything about your child's verbal and cognitive ability which may be useful for us to know?

5. Has your child had any previous negative experiences at the dentist?

6. Oral Hygiene at home

☐ **Brushes independently** ☐ **Parent helps to brush** ☐ **Flosses**

☐ **Uses manual toothbrush** ☐ **Uses electric toothbrush** ☐ **Uses toothpaste**

Any other information you would like to provide: