

Special Needs Dental Assessment

Patient Information

Full Name

Date of Birth

Gender

Contact/Carer Name

Contact Number

Medical History

Primary Diagnosis

Notable Medical Conditions

Current Medications

Allergies

Communication & Behaviour

Preferred Communication Method

Behavioural Considerations

Mobility & Support Needs

Mobility/Physical Aids

Specific Support Required

Oral Health Assessment

General Oral Health Status

Clinical Findings

Treatment Needed

Additional Notes

Other Relevant Information