

# MYDENTALCARE<sup>®</sup> PASSPORT



**For users:** This passport is unique to you. Please fill out all information that you think is important.

[You can find the Passport User Guide here.](#)

**For my dental team:** This is key reading for all staff working with me. It gives important information about how I can be supported when visiting your clinic. This passport should be kept visible and used when you talk to me or have a question about me. [You can find the Dental Team Passport User Guide here.](#)



Scan the QR Code  
to learn more.

## ABOUT ME

**My name is:**

I like to be called:

**My preferred pronoun is:**

☐ He ☐ She ☐ They ☐ Not listed

**I am my own guardian.**

☐ Yes ☐ No

**Please check the box that applies:**

☐ I completed this form myself.

☐ I completed this form with help from someone else.

**This is the best person to contact for more information about me:**

Name:

Phone:

Email:

**What type of disability do I have:**

Please list all disabilities below.

**The most important thing I want the dental team to know about me is:**

**On most days, I would describe myself as:**

Please check all that apply.

☐ Happy      ☐ Quiet      ☐ Nervous      ☐ Sleepy

☐ Loud      ☐ Angry      ☐ Other:

**My interests are:**

Please share any hobbies or interests so your dental team can get to know you better.



## COMMUNICATION AND BEHAVIOR

**Ways that I prefer to communicate with people:**

Please check all that apply.

- ☐ Talk to me directly, even if I bring someone with me.
- ☐ Use plain language.
- ☐ Give me time to process the questions.
- ☐ I have a speech impairment and can be difficult to understand.
- ☐ It takes time to form my words so please be patient.
- ☐ I am non-speaking, but I am communicating with you in other ways.
- ☐ Other:

**I communicate using:**

For example: speech, preferred language, sign language, communication devices or aids, pictures, non-speaking sounds. Please state if extra time or support is needed.

## Here are the ways I communicate some things:

Yes; Okay; I understand:

No; I do not understand:

Worried; scared:

Angry; frustrated:

Other:

## Here are visual or vocal cues that will be useful to know about me:



### Tip: Create a pause signal.

If you need the dental team to pause what they are doing at any time during a visit, you and your dental team can create a pause signal before you start.



# MOBILITY

## I use these aids to help me move:

## I can get into the dental chair on my own:

☐ Yes. ☐ No. ☐ Other:

## You can help me move by:

For example: help me get into the dental chair, extra space for me to move around, clearing wires from the floor where you can.



# SENSITIVITIES

There are some things at the dental office that cannot be taken away. However, there are things that you and the dental office can do to help make your dental visit more relaxing. Please add any information about what makes you feel upset or relaxed at the dental office below.

## **These are some things that can upset me:**

Please check all that apply. Please describe your needs.

- ☐ Smell:   
For example: dental office, perfume.
- ☐ Sounds:   
For example: phones, drill, voices, clock.
- ☐ Sight:   
For example: lights (overhead, dental light), mirrors.
- ☐ Positions:   
For example: chair tilt, being "still".
- ☐ Closeness:   
For example: people, objects.
- ☐ Touch or Temperature:   
For example: gloves, air, gauze, water, suction, tools, room, water temperature.
- ☐ Texture:   
For example: gauze, cotton, metal.
- ☐ Pressure:   
For example: seeking, aversion.
- ☐ Taste:   
For example: gloves, toothpaste, flavors.
- ☐ Other:

## **These are some things that can help me relax:**

Please check all that apply. Please describe your needs.

- ☐ Sounds:   
For example: earphones to block out noise, playing white noise, playing my favorite music, avoiding busy areas like the waiting room.
- ☐ Sight:   
For example: dimming or turning off overhead lights when possible, eye covers to block out light and activities.

- ☐ Closeness:   
For example: tell me before coming close to me, give me breaks from closeness.
- ☐ Touch, Temperature, Texture:   
For example: let me see the objects before we begin, tell me before a new touch, temperature, or texture happens.
- ☐ Pressure:   
For example: using a weighted blanket to help me feel comfortable.
- ☐ Taste:   
For example: tell me before there is a new taste, avoid a certain taste if you can.
- ☐ Feeling Safe:   
For example: having an object that helps me relax or feel secure, like a fidget spinner or security blanket.
- ☐ Other:

**These are the things I need to be comfortable in a dental chair:**

Please check all that apply.

- Support for: ☐ Neck ☐ Back ☐ Arms ☐ Knees ☐ Feet
- ☐ A weighted blanket.
- ☐ Stabilization support for spasms.
- ☐ Supportive stabilization security wrap.
- ☐ Head stabilization.



# DENTAL EXPERIENCE

**My best visit to the dental office was when:**

Share things that DID work well.

**My worst visit to the dental office was when:**

Share things that DID NOT work well.

**These are the things I sometimes do that you might find difficult in the dental office:**

For example: limb movements that may strike your hand when holding a dental tool.

**In the past, I had medication to stay calm during dental care.**

This is often called sedation. For example: laughing gas, pills to help you stay calm, I.V. sedation, general anesthetic in a hospital, etc.

☐ Yes. ☐ No.

If yes, describe what was used, if known.

This medicine made my dental visit easier.

☐ Yes. ☐ No.



## **OTHER THINGS YOU MIGHT NEED TO KNOW ABOUT ME**

**Please use this space for any further information you want the dental team to know.**



# MEDICAL HISTORY

The dental team will ask you about your medical history in detail. For your safety, it is important to know about your physical and mental health. You will be asked about your medical history every time you visit the dentist.

If it would be helpful for you, use the space below to keep a personal record of your medical history. This can be useful when you fill out health forms in the future.

## **My medical history:**

Include all medical conditions, such as diabetes, epilepsy, asthma, heart problems, depression, as well as past serious illnesses or surgeries, and other medical issues.

## **Please list all prescription and non-prescription medications:**