

Patient Accessibility Needs Form



For Office Use

Name: _____

Date of Birth: _____

Appointment Date: _____

1. Physical Accessibility Needs

Do you use any mobility aids? (Check all that apply)

☐ Wheelchair

Are you able to transfer from your wheelchair to a dental chair? ☐ Yes ☐ No

Do you need assistance transferring? ☐ Yes ☐ No

Do you need a Hoyer lift to transfer to a dental chair? ☐ Yes ☐ No

Is your wheelchair a power wheelchair that reclines? ☐ Yes ☐ No

☐ Walker

☐ Cane

☐ Crutches

☐ Other: _____

Do you need help getting in and out of the dental chair?

☐ Yes (If yes, please share the process.) _____

☐ No

Is there anything else that would help make the office easier for you to access (for example, a stepstool, or a wider exam room to bring a mobility aid in and out easily)?

2. Communication Accessibility Needs

How do you prefer to communicate with your dental team? (Check all that apply)

- ☐ Verbal expression
- ☐ Sign language
- ☐ Written notes
- ☐ Braille
- ☐ Picture or communication boards
- ☐ AAC Device or electronic communication board
- ☐ Other (Please explain.) _____

Do you use a device to communicate with?

- ☐ Yes (If yes, what device do you use?) _____
- ☐ No

Do you need an interpreter or translator?

- ☐ Yes (Please specify language.) _____
- ☐ No

Do you need extra time to communicate or understand information?

- ☐ Yes
- ☐ No

Do you prefer receiving information in simple language or pictures?

- ☐ Yes
- ☐ No

Is there anything else that would help you communicate better with your dentist?

3. Emotional and Sensory Needs

Do you have any sensitivities we should know about (like lights, sounds, smells)?

- ☐ Yes (If yes, please specify.) _____
- ☐ No

Do you prefer a quieter, sensory-friendly environment?

- ☐ Yes (If yes, please explain.) _____
- ☐ No

Do you have a service animal that will come to the appointment with you?

- ☐ Yes
- ☐ No

Do you have any emotional support needs during your visit (like calming techniques or having someone with you)?

- ☐ Yes (If yes, please specify.) _____
- ☐ No

Would you find it helpful to take breaks during your appointment for comfort?

- ☐ Yes (If yes, please explain.) _____
- ☐ No

Is it difficult for you to open your mouth all the way?

- ☐ Yes (If yes, please explain.) _____
- ☐ No

Is there something you want to speak privately about before your appointment?

- ☐ Any concerns that you have
- ☐ Things that stress you out
- ☐ Gag reflex concerns
- ☐ Fear of any typical tools used at the dentist office
- ☐ Protective stabilization (See *Dental Terms Glossary* for questions)
- ☐ Other (Please explain.) _____

Is there anything else we can do to make the environment more comfortable for you?

4. Additional Accommodations

Please list any other specific needs for your visit:

Completed by:

☐ Patient signature: _____

Date: _____

☐ Legal Guardian (if applicable): _____

Date: _____