FRENOTOMY INFANT HISTORY

Central CT Pediatric Dentistry and Orthodontics

Date: _____

Patient Name: _____M ☐ F ☐ DOB: _____ Weight _____

Address: _____City: _____State _____Zip _____

ACCOUNT INFORMATION

FATHER'S NAME: _____ MOTHER'S NAME: _____

ADDRESS: _____ ADDRESS: _____

PHONE (HOME): _____(WORK): _____ PHONE (HOME): _____(WORK): _____

CELL: _____ CELL: _____

EMAIL: _____ EMAIL: _____

EMPLOYER/DIVISION: _____ EMPLOYER/DIVISION: _____

ADDRESS: _____ ADDRESS: _____

DENTAL INS. CO.: _____ DENTAL INS. CO.: _____

INS. ADDRESS: _____ INS. ADDRESS: _____

POLICY # _____ POLICY # _____

SOCIAL SECURITY # _____ SOCIAL SECURITY # _____

DATE OF BIRTH: _____ DATE OF BIRTH: _____

Child's Physician _____Address: _____ Phone: _____
Date of last visit: _____
Referred by: _____

HISTORY

1. Is there a family history of tongue tie, feeding problems and/or early speech pronunciation problems? ☐ Yes ☐ No
   If yes, please explain. _____
2. Is there any family history of bleeding disorders? ☐ Yes ☐ No
3. If male, was circumcision done? ☐ Yes ☐ No
3. Medicine, supplements: List Medicine _____
4. Birth History: Gestational age: _____ Vaginal or Cesarean _____ Jaundice _____ Phototherapy _____
5. Family or patient latex allergy? ☐ Yes ☐ No

Mother's Symptoms

- ☐ Pain when infant at breast
- ☐ Nipples damaged, cracked, or bleeding
- ☐ Nipple compressed or misshapen after feed
- ☐ Feels different than with previous child
- ☐ Mastitis
- ☐ Plugged ducts and painful breast
- ☐ Other

Baby Symptoms

- ☐ Trouble latching with wide splay
- ☐ Falls off breast or down to just the nipple
- ☐ Chomps or bites breast
- ☐ Can only nurse with a nipple shield
- ☐ Frustrated at breast despite different holds
- ☐ Clicking sound when feeding at breast ___ at bottle ____
- ☐ How long is feeding? _____
- ☐ How much time between feedings? _____

Previous Care

- ☐ Working with lactation consultant
- ☐ Getting bodywork, craniosacral, physical therapy (circle which ones)
- ☐ Has already had a frenotomy

Permission for treatment upon a minor

The above information I have given is correct to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my child's medical status. I, being the parent or guardian of the above minor patient have authorization and do request and authorize the performance of dental services for this patient, and the performance of whatever procedures or techniques the Doctor may deem necessary during performance of any operation or treatment. I authorize the administration of anesthetics or analgesics, which may be deemed advisable by the Doctor. I will be informed of all services and their charges by this office before any of the services are rendered.
Furthermore, I understand as the parent or guardian who accompanies the child I will be responsible for all financial obligations incurred on this child for dental treatment.
I give my permission to use these records for consultations and educational purposes.

This information was provided by and discussed with: _____-
(Signature of Parent/Guardian and Relationship to Child)