Personal Information:
Baby Name: _____ DOB: _____
Parent Names: _____
Home Address: _____
Cell #: _____ AHC#: _____ Email: _____
Pediatrician Name: _____
Referred by:_____

Medical History:
Baby's Birth weight: _____ Baby's current weight: _____ Vaginal Birth: ____ C-Section: ___
Was your infant premature? Y/ N
Does your infant have any heart disease? Y / N, If yes please explain_____
Has your infant had any surgery? Y/N, explain _____
Is your child taking any medications? Y/ N, If yes please list _____
Did your infant received vitamin K shot at birth to prevent bleeding in the first 8 weeks of life? Y/N, If not please explain_____
Do you, your baby or any immediate family have any bleeding disorders? Y/ N
Are you currently breastfeeding? Y/ N Supplementing with bottle? Y / N
Have you chosen not to breastfeed? Y / N
Are you using a nipple shield? Y / N Are you using a SNS device? Y/ N
Has your child ever been evaluated for a tongue/lip tie? Y / N
Did your infant have any prior surgery for tongue or lip ties? Y / N

Infant's Symptoms: (check all that apply)
__ Difficulty achieving a good latch
__ Colic and/or irritability
__ Gassy
__ Makes clicking noises while sucking
__ Choking, couching or gulping during feeds
__ Poor weight gain or weight loss
__ Gumming, chewing or clamping on nipple
__ Slides of breast when trying to latch
__ Pacifier falls out of mouth easily
__ Shallow latch
__ Reflux symptoms
__ Milk dribbles out of mouth when nursing
__ Baby frustrated when feeding
__ Falls asleep while nursing
__ Upper lip curls in when nursing/ bottle fed
__ Apnea (snoring, mouth breathing)
How long does it take your baby to nurse or bottle feed? _____

Mother's Symptoms: (check all that apply)
__ Cracked/ bleeding nipples
__ Low milk supply
__ Over supply
__ Poor or incomplete drainage
__ Mastitis / Thrush
__ Infant unable to latch
__ Plugged ducts/ engorgement
__ Pain during nursing, Pain scale (1-10) when first latch ____

Consent to Treatment and Permit for Operations
Please ask us about our privacy policy for more information. This is to certify that I, the undersigned consent to the performing of the dental and oral surgery procedure agreed to be necessary or advisable, and I will assume responsibility for the fees associated with those procedures.

SIGNATURE: _____ DATE: _____