Walla Walla Pediatric Dentistry
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PATIENT'S CONFIDENTIAL INFORMATION – FRENOTOMY & FRENECTOMY

Patient Information

Child's Name: ______________________________ **Sex:** ☐ M ☐ F **Date of Birth:** ____________

Contact Information: Preferred Phone #____________________ **Text:** ☐ Yes ☐ No

Alternate Phone #____________________ **Email:** ______________________________

Address: ______________________________ **City:** ______________ **State:** ______ **Zip:** ________

Lactation Consultant: ______________________________ Phone # ____________________

Pediatrician: ______________________________ Phone # ____________________

Who referred you for this service? ____

☐ **Home Birth** ☐ **Hospital Birth** ☐ **Vaginal Birth** ☐ **C-Section Birth**

Birth Weight (lb/oz): ______________ **Current Weight (lb/oz):** ______________

Any family history of bleeding disorders? ☐ Yes ☐ No

Is there a family history of ☐ Tongue Tie ☐ Lip Tie?

Are you presently breastfeeding? ☐ Yes ☐ No

Parent/Guardian Information

Father/Guardian Name: ____________________
Address: Same as patient? ☐ Yes ☐ No
If not, please list: ____________________
City: ______________ **State:** ______ **Zip:** ______
Home: ________ **Work:** ________ **Cell:** ________
Occupation: ____________________
Employer: ____________________
Date of Birth: ______________

Mother/Guardian Name: ____________________
Address: Same as patient? ☐ Yes ☐ No
If not, please list: ____________________
City: ______________ **State:** ______ **Zip:** ______
Home: ________ **Work:** ________ **Cell:** ________
Occupation: ____________________
Employer: ____________________
Date of Birth: ______________

In the event of an emergency, whom should we contact? Someone other than Parent/Guardian

Name: ____________________ **Relationship:** ______________ **Phone:** ______________

Medical History

1. Infants are usually given Vitamin K at birth to prevent bleeding in the first 8 weeks of life.
   Did your child receive the Vitamin K injection? ☐ Yes ☐ No
2. Was your infant premature? ☐ Yes ☐ No If yes, gestational age (wks): ________
3. Does your infant have any heart disease? ☐ Yes ☐ No If yes, ____________________
4. Has your infant had any surgery? ☐ Yes ☐ No If yes, ____________________
5. Has the child had prior surgery to correct tongue or lip tie? ☐ Yes ☐ No
   If yes, when and where ____
6. Does your infant have any allergies? ☐ Yes ☐ No If yes, ____________________

Baby's Symptoms

- ☐ Poor latch
- ☐ Falls asleep while attempting to nurse
- ☐ Slides off the nipple when attempting to latch
- ☐ Colic symptoms
- ☐ Reflux symptoms
- ☐ Poor weight gain
- ☐ Gumming or chewing of your nipple when nursing
- ☐ Unable to hold a pacifier in mouth
- ☐ Short sleeping requiring feedings every 2-3 hours
- ☐ Snoring ☐ Heavy breathing ☐ Sleep apnea
- ☐ Cyanosis (turning blue)
- ☐ Bleeding problems

Mother's Symptoms

- ☐ Creased, flattened, or blanched nipples after nursing
- ☐ Blistered, cracked, or bruised nipples
- ☐ Bleeding nipples
- ☐ Severe pain when your infant attempts to latch
- ☐ Poor or incomplete breast drainage
- ☐ Infected nipples or breasts
- ☐ Plugged ducts
- ☐ Mastitis

Signature of Parent/Guardian: ________________________________ **Date:** ______________