GLEN PARK DENTAL
Beautiful Smiles for Life

INFANT TONGUE/LIP TIE EVALUATION

Today's Date: _____ Patient's DOB: _____ Patient's age _____ Sex:

Patient's Name: _____ Primary Phone: _____

Parent's Name(s): _____ Email: _____

Address: _____ City, State: _____ Zip: _____

Insurance Subscriber DOB: _____ Insurance Subscriber ID: _____ Insurance Subscriber SSN: _____

Main Concerns: _____

_____

Pediatrician's Name: _____

Are you currently working with a lactation consultant? ❍Yes ❍No If so, who? _____

Is your infant currently being seen for bodywork (chiropractor, physical therapist, osteopath, occupational therapist, other)? ❍Yes ❍No

If yes, what type and by whom? _____ Total visits: _____

Is this your first child? ❍Yes ❍No Family history of tongue tie? ❍Yes ❍No

Has Dr. Pinto treated you or a family member in the past? ❍Yes ❍No If so, who/when? _____

How did you hear about our office? _____

MEDICAL HISTORY

Birth weight (lb/oz): _____ Most current weight and (lb/oz): _____

Food allergies? ❍Yes ❍No If yes, which food(s): _____

Medication allergies? ❍Yes ❍No If yes, which medication(s): _____

List all current maternal and infant medications/supplements: _____

Are vaccines up to date? ❍Yes ❍No

Did your infant receive Vitamin K injections? ❍Yes ❍No

Does your infant have any heart diseases? ❍Yes ❍No

Has your infant had any surgeries? ❍Yes ❍No If yes, what type(s) and when: _____

Has your infant had prior surgery to correct the tongue or lip tie? ❍Yes ❍No

If yes, what type(s) and where: _____

Does your infant have any other medical conditions or health concerns? ❍Yes ❍No

If yes, what type(s): _____

PREGNANCY/LABOR HISTORY: Normal or High Risk (please circle)

Birth Location _____

Was your infant premature? ❍Yes ❍No If yes, gestational age at birth: _____

Were there any additional stressors with labor? ❍Yes ❍No

Please circle: Long Labor / Excessive Pushing Breech Birth Unplanned C-Section Trauma from Vacuum or Forceps

Other (please explain): _____

Difficulty with latch after birth? ❍Yes ❍No If yes, please explain: _____

MODE OF FEEDING

Is this your first time breastfeeding? ❍N/A ❍Yes ❍No Other breastfed children/how long? _____

Are you supplementing with pumped breast milk? ❍Yes ❍No If yes, how many bottles/ounces per day? _____

Are you supplementing with formula? ❍Yes ❍No If yes, how many bottles/ounces per day? _____

Are you using SNS or any other supplementer? ❍Yes ❍No Are you currently using a nipple shield? ❍Yes ❍No

How would you rate your milk supply? ❍Oversupply ❍Good ❍Fair ❍Poor

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BABY'S SYMPTOMS

Does your infant fall asleep while attempting to nurse?	❍Yes	❍Sometimes	❍No
Does your infant slide off breast when latching/feeding?	❍Yes	❍Sometimes	❍No
Does his/her upper lip curl inward (does not flip out) when latched?	❍Yes	❍Sometimes	❍No
Does your infant have his/her mouth open at rest?	❍Yes	❍Sometimes	❍No
Does milk or formula leak/spill out of mouth while feeding at breast/bottle?	❍Yes	❍Sometimes	❍No
Is your infant experiencing colic symptoms?	❍Yes	❍Sometimes	❍No
Does your infant become visibly frustrated at the breast?	❍Yes	❍Sometimes	❍No
Does your infant exhibit reflux symptoms?	❍Yes	❍Sometimes	❍No
Has your infant been diagnosed with reflux by a pediatrician?	❍Yes	❍Sometimes	❍No
Is your infant extremely gassy?	❍Yes	❍Sometimes	❍No
Has your doctor noticed slow or poor weight gain?	❍Yes	❍Sometimes	❍No
Have you done any pre- and post- feeding weight checks?			
If so, what was the transfer rate:_____ounces per_____minutes	❍Yes	❍Sometimes	❍No
Does your infant display gumming or chewing of your nipple while nursing? Is	❍Yes	❍Sometimes	❍No
there a noticeable "clicking noise" while feeding?	❍Yes	❍Sometimes	❍No
If yes, is it frequent?	❍Yes	❍Sometimes	❍No
Does your infant seem satisfied/content after nursing sessions?	❍Yes	❍Sometimes	❍No

If not, please explain: _____

What is the average length of feeding time at breast in minutes? (Please circle) Less than 15 15-30 30-45 45-60 60+

MOTHER'S SYMPTOMS

Please rate your level of discomfort while feeding or when you did breastfeed:

N/A0 None 1 Very Low 2 Low 3 Medium4 High 5 Very High N/A

Are you noticing your nipples becoming creased/flattened/lipstick shaped/blanched white after nursing?	❍Yes	❍No
If yes, please circle: Right Side Left Side Both		
Are your nipples becoming cracked, bruised or blistered after nursing?	❍Yes	❍No
If yes, please circle: Right Side Left Side Both		
Are your nipples bleeding?	❍Yes	❍No
If yes, please circle: Right Side Left Side Both		
Is there any severe pain when your infant attempts to latch?	❍Yes	❍No
If yes, please circle: Right Side Left Side Both		
Are you experiencing poor or incomplete breast drainage?	❍Yes	❍No
Do you have a history of, or currently have, mastitis?	❍Yes	❍No
Do you have a history of, or currently have, nipple/infant oral thrush?	❍Yes	❍No

In a sentence or two, please share your current breastfeeding concerns:

_____

_____

In a sentence or two, please share your breastfeeding goals:

_____

_____

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Medical Information Release Form (HIPAA Release Form)

NAME: _____ DATE OF BIRTH: ___/___/_____

Release of information

[ ] **I hereby authorize** Dr. Kimberlee Dickerson and affiliates, employees, or agents to release any personal health information (e.g., information relating to the diagnosis, records, treatment, claims payment, and healthcare services)

Parent/Spouse/ Relative _____

Referring Provider _____

Pediatrician _____

Lactation Consultant _____

Bodyworker/Doula/Midwife/Other _____

(DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY)

[ ] **I do not authorize** Dr. Kimberlee Dickerson or affiliates to release any medical information ***This*Release of Information** *will remain in effect until terminated by me in writing.* ***Messages***

Please call [ ] My Home [ ] My work [ ] My Cell # _____

If unable to reach me:

[ ] You may leave a detailed message

[ ] Please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day) _____ Between (time) _____

Signed: _____ Date: __/___/_____

Witness: _____ Date:__/__/_____