CONTRIBUTED BY
Dr. Stacey Cole, DDS

Infant Questionnaire

Patient Name:_____ Birth Date:_____ Today's Date:_____

Birth Weight: _____ Present Weight:_____

Address:_____ City:_____ State:_____ Zip:_____
Referred by:_____ Phone: _____
Pediatrician:_____ Phone: _____
Lactation Consultant:_____ Phone: _____
Have you visited my website? YES NO

Medical History: Has your child experienced any of the following problems or treatment?

1. Received vitamin K injections? YES NO
2. Does your infant have heart disease? YES NO
3. Was your infant premature? YES NO
4. Has your infant had any surgery? YES NO
5. Is your infant taking any medication? YES NO
6. Has your infant experienced any of the following?

_____ Poor latch
_____ Falls asleep while attempting to latch?
_____ 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 his or her mouth
_____ Unable to use a bottle
_____ Short sleep episodes requiring feedings every 2-3 hours

7. Do you have any of the following signs or symptoms?

_____ Creased, flattened or blanched nipples after nursing
_____ Cracked, bruised or blistered nipples
_____ Bleeding nipples
_____ Severe pain when your infant attempts to latch
_____ Poor or incomplete breast drainage
_____ Infected nipples or breasts
_____ Plugged ducts
_____ Mastitis or nipple thrush

ADDITIONAL COMMENTS OR CONCERNS BACK

Thank you for scheduling an appointment with me. The goal of this consultation is to determine if there is a physical oral problem affecting your ability to breastfeed your baby.

Please answer the following questions so that I may better understand your current breastfeeding issues.

Patient name:_____

D.O.B. _____ Birth Weight:_____ Current Weight: _____Today's date:_____

Birth History: Full term Y/N Vaginal/C-Section Forceps /Vacuum assisted Y/N

Mother- Do you have any of the following (please check all that apply).

- Painful nursing
- Are your nipples, bruised, cracked, blistered, blanched, flattened, lipstick shaped, bleeding or misshaped nipples after nursing?
- Breast swelling or Clogged ducts
- Mastitis
- Thrush of the nipples

Do you use a shield to breastfeed? _____

How many times a day do you breastfeed?_____ How long for each side?_____

Infant-Does any of the following apply (please check all that apply)
Was your baby previously diagnosed with a lip or tongue tie? Y/N
If yes, was it treated somewhere else? Y/N
If yes, when_____ where_____ how_____ by who_____ ?

When nursed is the feeding:

- Prolonged or incomplete
- Baby bobs mouth on and off to latch
- Baby falls off the breast and sleeps
- lip or tongue feels weak
- lip or tongue cycles through sucking and movement for a short time then stops and recycles
- Baby slides off of the nipple
- Chronic burping or flatulence
- Distended or bloated belly
- Signs of reflux such as chronic spitting up, gagging or vomiting
- Signs of discomfort such as arching of the back or clenching of the hands
- Clicking noise or loss of suction while nursing: none, occasional, frequent, inconsistent
- Breast milk leakage from mouth, nose or both
- Does your baby's tongue feel like sandpaper rubbing against you? Y/N
- Is there a crease mark on your baby's upper lip after nursing? Y/N
- Is your baby losing weight? If yes, how much? _____ Y/N
- Does nursing feel like there is drinking or gulping? (circle)
- Do you supplement with a bottle to assist with proper feeding? Y/N
- Is there a sustained strong or clamping latch? Y/N

Any other nursing concerns

_____

_____

CONTRIBUTED BY
Martin A. Kaplan DMD

Infant Frenectomy Consultation Considerations

Patient name _____

D.O.B_____ Date: _____

Doctor Exam: Visual and Digital Classification of the lip tie: 1 2 3 4

Vital Signs: HR_____ Oxygen_____ RR_____ Temp._____

- **Lip evaluation:**
- **Callus present on the upper lip? Y / N**
- **Defined Philtrum? Y / N**
- **Full upper lip? Y / N**
- **Upper lip curls up and out (flanges)? Y / N**
- **Lip purses? Y / N**
- **Upper lip stretches and rolls to the tip of the nose? Y / N**
- **Gums blanch when raising lip? Y / N**
- **Muscle tone tight or flexible**

Tongue evaluation:

- **Anterior Tongue-Tie: none / slight/ moderate / severe**

1. **Barrier to finger sweep: fence / speed bump**
2. **Blanches gum when tongue retracts**
3. **Sore or blister on tip of tongue**

- **Shape of Tongue: Notched / forked / cupped / heart-shaped / folds down /callous**

- **Posterior tie:(posterior finger speed bump, tenting or cord)**

1. **None**
2. **Short / long**
3. **lingual fiber :Thin/ Thick**
4. **Deep / Hidden (seen with retraction)**

- **Finger suction: None weak strong**
- **Tongue cycle: continuous progressive wave - short burst with prolonged rest - limited to very weak peristalsis- pistons in and out – incomplete tongue wave**
- **Tongue : posterior elevation / anterior point/ sides curl**
- **Palate: Flat high arched**

- **Asymmetry: Head: R/L Face: R/L Jaw: R/L Neck: R/L Posture: R/L/anterior**

- **other_____**

We would like to welcome you and your child to our office. Our practice goal is to improve the lives of children by optimizing their oral health, which will benefit their overall wellness. We will accomplish this state of the art treatment with a friendly approach focusing on the child's special needs.

Patient Information

Name: _____
Nickname: _____
Date of Birth: _____ Male___ Female___
Social Security #_____
Home Address:_____

Parent/Guardian Information

Name: _____
Relationship to patient:_____
Home Address (if different):_____
Phone numbers: Home:_____ Work: _____ Mobile: _____
Email address: _____

Dental Insurance Information

Insurance Company Name: _____ Group# _____
Insurance Company Phone: _____
Insured Name: _____ Relationship to patient:_____
Insured SSN: _____ Insured Date of Birth:_____
Insured Employer:_____

Medical History

Birth History:
( ) Full Term Birth or ( )Premature Birth _____ weeks
Any birth complications? ( )No ( )Yes: _____
Any medical issues after birth? ( )No ( )Yes:_____
Hospital/Birthing Center/Home birth:_____
Birth Weight: _____ Current Weight: _____
Breast Feeding ( )yes ( )no Bottle Feeding ( )no ( )yes --Breastmilk /Formula _____
Breastfeeding Problems:
( ) Latch Issues ( ) Milk Transfer Issues ( ) Excessive Air/Gas ( ) Lip Blister
( ) Staying on Breast ( ) Long BF Sessions ( ) Feeding Frequency ( ) Reflux
( ) Maternal Pain/Symptoms _____
Has your child had any of the following conditions?
( ) Anemia ( ) Heart Condition
( ) Asthma or Lung Problems ( ) Failure to Gain Weight
( ) Kidney Disease ( ) HIV
( ) Bleeding Disorder ( ) Hearing Impairment

( ) Cerebral Palsy ( ) Jaundice
( ) Cleft Lip/ Cleft Palate ( ) Sickle Cell Anemia
( ) Delayed Development
Any problems not listed above ()No ()Yes:_____
Please list all medications your child is currently taken: ( ) None

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Is Your Child ALLERGIC or has your child had an ADVERSE REACTION to any medication?
( )No ()Yes: _____

Surgeries or Anesthesia History: ( ) None
Any history of life--threatening anesthesia complications in the family? ( )No ()Yes:
_____
Primary Physician/Pediatrician:_____
Other Physicians/Specialists:_____

I understand that the information that I have given is correct to the best of my knowledge and it is my responsibility to inform the office of any changes in my child's medical status.

Name_____ Signature_____
(Parent/Guardian)

Date: _____

INTAKE QUESTIONS FOR INFANT FRENECTOMIES

Date Called: _____ Appointment Date: _____

Child's name _____ DOB _____

Parent's Name _____

Phone Number _____

Email address _____

Were emails sent? Yes No

Referred by _____

Using a Lactations Consultant? Yes No

Is child nursing or bottle fed? _____

Chief problems noted for baby:

_____

Lip Tongue Both

Chief problems noted for mom:

_____

Does the child have any other health problems? Yes No

_____

Is there Dental Insurance and is child covered under Dental? Yes No

Insurance Company _____

Insurance Phone # _____

Subscriber Name _____

Subscriber DOB _____

Subscriber SSN _____

Member ID # _____

Dr. Skowronski would prefer you to email her some pictures of the areas of concern. Dr. Skowronski will review the pictures and let you know if she feels it's necessary to have the procedure done.

The cost of the procedure is $290.00, whether just the one is done or both and this is due the day of the procedure. If only coming in for a consult it will be $87.00, this will be waived if the procedure is done the same day, then it will be $290.00.

Few insurance companies cover this, but if your child has dental insurance I would be more than happy to check on this prior to the appointment. Medical codes will be given to you if you choose to see if your medical insurance will reimburse you for the frenectomy.

Dr. Skowronski uses a soft tissue laser to do the procedure. The actual procedure takes roughly under a minute per site.

We schedule these procedures on Thursdays.

We do NOT do this procedure if older than 1 year, unless approved by Dr. Skowronski. Pictures and email text must be emailed to Dr. Skowronski before any appointment can be made if older than 1 year.

The day of the procedure we ask you to bring a swaddler or blanket and also not to feed your child 2 hours prior to the appointment, so that Dr. Skowronski can have you feed your child prior to the procedure to see how they feed. She will again have you feed your child after the procedure. Dr. Skowronski will consult with you prior to the procedure to evaluate your child, take photos, see how your child feeds and answer any and all questions you may have.

Please feel free to email or call the office if you have any other questions that you may think of prior to the appointment. I will email the health history to you, please make sure you fill this out and either email it back or bring it with you the day of the appointment.

Thank you and I look forward to seeing you on (day of appointment).

Dr. Larry Kotlow in Albany, NY is an expert in this field, contact if there are any questions our office can't or has not answered. His contact info is: 340 Fuller Rd., Albany, NY 12203, (518)489-2571.

PICTURE INSTRUCTIONS: Its best to have someone help you, lay the baby in your lap with the baby's head closest to you and their feet pointing away. Elevate the baby's lip up and have the other person take the picture, elevate the tongue up and have the other person take the picture. It's helpful if the baby is crying to take the tongue picture.

PATIENT INFORMATION

NAME _____ DATE _____

ADDRESS _____

_____

DOB _____ GENDER: MALE ____ FEMALE ____ PHONE # _____

EMAIL _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____

Relationship to Patient _____ Phone # (If Different) _____

Address (If Different) _____

MOTHER SYMPTOMS

Please Circle all that apply:

- Painful Feeding
- Bruised, Cracked, Blistered, Flattened or Bleeding Nipples
- Breast Swelling
- Mastitis
- Thrush of the Nipples
- Use Nipple Shield to Breastfeed

How many times daily do you breastfeed? _____

Additional Information regarding your health that should be considered:

_____

_____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? _____

I ACKNOWLEDGE THAT I HAVE RECEIVED THE "NOTICE OF PRIVACY PRACTICES" FROM THE OFFICE.

Signature _____ Date _____

INFANT (Please Circle ALL that applies to your child)

- Prolonged Nursing
- Incomplete Nursing
- Baby falls off the breast and sleeps
- Lip or Tongue feels weak
- Baby slides off of the nipple
- Chronic burping or flatulence
- Distended or bloated belly
- Signs or discomfort such as arching of back or clenching of the hands
- Clicking noises while nursing
- Lip or tongue cycles through sucking and movement for a short time then stops and recycles

Are there signs of gagging? Y / N
Is your baby losing weight? Y / N
Do you supplement with a bottle to assist with proper feeding? Y / N

Additional Information regarding your child's health that should be considered:

_____

_____

_____

_____

Pediatrician's Name _____ Phone _____

Medications _____

Allergies _____

Signature _____ Date _____

Relationship to Patient _____

Reviewed by _____ Date _____