Dr. Lynn lamont Laser Dentistry & Photobiomodulation
300 Crown Street Saint John NB E2L 2Y4 506-633-8800
lynnlamont@rogers.com

Patient Name: _____ Sex : F___ M___
Date of Birth : _____
Address _____

_____

Phone # : Home_____Work_____

Email Address: _____

Medicare # : _____

Dental Insurance ___YES ___No

Name of the insurer : _____

Insurance Company : _____

Address : _____

Phone # _____

Policy # :_____ ID# : _____

Parent or Guardian (if under 18) or next of Kin_____
Person responsible for payment: Self or _____

Physician Name : _____

Address : _____

Phone # _____

Who referred you to us? _____

_____ _____
Signature of Patient Date

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Tongue / Lip Tie Questionnaire

Patients Name _____ Birthday _____ Age___
Medical Issues:_____ Taking Medications:_____
Allergies:_____ Previous release or clip of tongue?_____ Date_____
Family History of Bleeding Disorder? __Yes __No

Has your child experienced any of the following issues? Please check or elaborate as needed.

Speech

__ Frustration with communication
__ Difficult to understand
__ % of the time you understand your child
__ Difficult getting words out (groping for words)
__ Delayed speech
__ Stuttering
__ Baby Talk
__ Mumbling or speaking softly
__ Speech Therapy (when)_____
__ Trouble with certain letters (pronounce?)
__ K , G , F , T , D , N , S , Z
__ Are words with : Th , B, V, C , M , PL, not clear
__ Uses "cu" for cup or" wed" for red

Feeding

__ Frustrated with eating
__ Difficulty transitioning to solid foods
__ Slow eater (doesn't finish meals
__ Grazes on food throughout the day
__ Packing food in cheeks like a chipmunk
__Picky with textures?_____
__ Choking or gagging on food
__ Spits out food
__ Swallowing difficulties
__ Trouble using a straw or sippy cup
__ Difficulty using a spoon,
__ A messy eater, food on face
__ Difficulty eating an ice cream cone
__ Frequent upset stomach, gas, hiccups

Seep Issues

__ Sleeps in strange positions
__ Kicks and flails around at night
__ Wakes easily or often
__ Wets the bed
__ Wakes up tired and not refreshed
__Sleeps with mouth open
__ Snores while sleeping (how often?)
__ Morning headaches
__ Daytime sleepiness
__ Morning fatigue
__ Irritability / Defiant / Angry

Nursing Issues as Baby

__ Painful nursing or shallow latch
__ Poor weight gain
__ Reflux or spitting up
__ Unable to hold pacifier
__ Milk dribbling out of mouth
__ Clicking or smacking noises when eating
__ Poor supply
__ Nipple shield required for nursing

Other related Issues

__Neck or shoulder pain or tension
__ Headaches or migraines
__ Mouth open / mouth breather during the day
__ Ear tubes
__ ADHD / ADD
__ Constipation
__ Growth & Development Issues : CL II , retrognathic mandible, anterior open bite
__ Grinds teeth / bruxism
__ TMJ pain, clicking, or popping
__ Strong gag reflex
__ Tonsils or adenoids previously removed
__ Reflux (medicated or not)
__ Recurrent sinus infection
__ Tongue protruding out of mouth (thrusting)
__ Lower Anterior crowding & wear

Active Wound Management for Frenectomies

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Office 506- 633-8800 // Home 506-693-2935

Your goal is to have the frenum heal and re-form as far back as possible. You should do the lifts with the child laying down on a bed or couch facing away from you like the dental examination. Please follow-up within 7-10 days after the surgery.. Begin doing the lifts the day of the procedure with clean hands and trimmed nails

To maintain wound opening during healing, lift lip or tongue by fully elevating the tissue with slight tension so you can visualize the diamond shape wound. Be gentle but firm to be effective, you want the diamond taller than wider to get the best possible length of extension.

The Rule of Five : 5 repetition , 5 times a day , for 5 weeks.

Lifts:

Lip : Lift lip up and out to reach the nose
Place tongue under lip and push up and move side to side

Tongue : Lift tongue to reach the top of your mouth (palate) and slide to the back of your throat.
Stick your tongue out as far as can to touch your chin.
Move your tongue to lick the corners of your lip.
Reach the tip of your tongue into the cheek area of your back molars.

Myofunctional Therapy

Optimizing Oral Function

1. Nasal Breathing
2. Lip Competence
3. Correct Resting Tongue Position (entire tongue(front, middle, back) flat on the roof of mouth)
4. Correct swallowing Pattern (mouth closed)

Number of fun activities to encourage children to move the tongue and lip , see office handout

Follow Up Care

Suggested follow -up appointments : 1 week, 5 week, 6 month, 1 year
Visits to : Myofunctional Therapist
Bodyworker -- Chiropractor, Craniosacral Therapist , massage Therapist
Speech Therapist

Myofacial Exercises for Tethered Oral Tissues

Toddlers

1. Lip rounding
2. Fish face
3. Oral Teethers : O-Ball, Beckman Tri-chew, Wowie starfish, Innobaby Ez Grip Training Teether, Zoli Bunny
4. Start cup drinking as early as 11 months (will be messy)

Young Child, Teen & Adult

Make it Fun. Make rumbling noises.

5. Retract straight back
6. Protrude straight forward
7. Laterization laser beam : move tongue towards swizzle stick or between the swizzle sticks.
8. Jelly Fish : fat tongue / skinny tongue
9. Open wide : reach for the top (elevate tongue); then PEE PEE dance - in & out without moving jaw.
10. The Umbrella : tongue to incisive papilla (the spot) then balloon wide. (skinny tongue to spot then fat tongue to spot)
11. The Dolphin Flipper : reach for chin / elevate towards nose >> Do Not move jaw.
12. The Marshmallow Hunter : Place food at the buccal vestibular near last molar, try
    The Cheerio Hunter : to retrieve the food. Do both the both arches, one at a Time.

#12 is the best exercise >> retraction, elevation, backward extension, & lateralization

13. The Sad Bears : they need a hug (place a gummy bear on the tongue and push it against the roof of the mouth, let it melt as you keep the tongue elevated). This activates the tip and middle of tongue for nasal Breathing
14. Tongue - Lip Dance Challenge : Both lip and tongue must move independently of each Other.
15. Lick an ice-cream cone
16. Lick a spoon
17. Lick inside of a glass or cup coated with something good.
18. Put Peanut butter on the roof of the mouth and to swallow it (activate correct swallowing pattern).

Be creative & act foolish >> have fun >> think about function : Tongue Ballet, Zombie Tongue, Bunny Barrows

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300 Crown Street. New Brunswick

DIAGNOSIS: I have been informed of the presence of a frenum that might be exceptionally short, thick, tight, or may extend too far down along the gum. When a frenum is positioned in such a way as to interfere with the normal alignment of teeth or to impinge on the gingiva (gums), it can be excised with a surgery called a Frenectomy

PURPOSE OF FRENECTOMY SURGERY: A Frenectomy is a surgical procedure that removes or loosens a band of tissue that is connected to the lip, cheek or floor of the mouth. The surgery can cause very little bleeding, does not require sutures, and often results in some post-procedure discomfort. The procedure will be performed using a local anesthetic on patients older than two and a topical anesthetic or infrared light therapy on patients under the age of two.

RISKS RELATED TO THE SUGGESTED TREATMENT:.While this could be considered a low risk procedure risks related to Frenectomy surgery might include post-surgical infection, bleeding while brushing, swelling, or pain. Risks related to the anesthetics might include but are not limited to allergic reactions, accidental swallowing of foreign matter, facial swelling or bruising, pain, soreness or discoloration at the sign of the anesthesia.

NO WARRANTY OR GUARANTEE: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed surgery will be completely successful in reducing the interference with the normal alignment of the teeth or impingement on the gingiva (gums). It may need to be retreated. It is anticipated (hoped) that the surgery will provide benefit in reducing the cause of this condition. Due to individual patient differences, however, one cannot predict the absolute certainty of success. Therefore there exists the risk of failure, relapse, selective retreatment, or worsening of my present condition, including the possible loss of certain teeth with advanced involvement, despite the best of care.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, filming, recording and x-rays of my oral structure as related to these procedures.

CONSENT TO UNFORESEEN CONDITIONS: During surgery, unforeseen conditions may be discovered which call for a modification or change from the anticipated surgical plan. I therefore consent to the performance of such additional or alternative procedures as deemed necessary in the best judgment of the treating doctor.

COMPLIANCE WITH SELF-CARE INSTRUCTIONS: I understand that excessive smoking and/or alcohol intake may affect healing and may limit the success of my surgery. I agree to follow instructions related to my own daily care of my mouth. I also understand aerobic exercise can cause the loss of a clot with bleeding and possibly reduce success to the outcome of this surgical procedure. I agree to report for appointments following my surgery as suggested so that my healing may be monitored and the doctor can evaluate and report on the outcome of the surgery upon completion of healing.

COMPLIANCE WITH FOLLOW UP: Follow-up with other members of the team; IBCLC, Myofunctional Therapist, Bodywork Therapist, and /or Speech Therapist. Failure to do so may results in reattachment of the tethered oral tissues.

PATIENT'S ENDORSEMENT: My endorsement (signature) to this form indicates that I have read and fully understand the terms and words within this document and the explanations referred to or implied, and that after thorough deliberation, I give my consent for the performance of any and all procedures related to Frenectomy surgery

as presented to me during consultation and treatment plan presentation by the doctor or as described in this document. I have read and fully understood the terms within this document and consent to the procedure as described above.

Signature of the Patient	Date	Name of the Patient
Signature of the Patient's Guardian	Date	Relationship to Patient
Signature of Witness	Date	