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Date Y M D

Mr. Mrs. Ms. Surname Given Name Middle Initial

Chart No. —

Date of Birth: Y M D

Sex: M____ F____

Address _____

City _____ Postal Code

Occupation _____

Phone Home _____ Work _____

Medicare _____ email _____

Dental Insurance Yes_____ No_____

Parent or Guardian (if under 18) or Next of Kin _____ Phone #_____

Person responsible for payment: Self or _____ (specify) Phone #_____

Insurance Co. _____ Personal Physician _____

Address _____ Address _____

Phone _____ Phone _____

CONSENT TO TREATMENT

I have had the treatment procedure(s) and the estimated fee for the procedure(s) contained in the treatment plan dated _____ explained to me, I understand their significance and I consent to the treatment procedure(s).

_____
Signature of Parent/Guardian

_____
Doctor

Date_____

Dr. Lynn Lamont Laser Dentistry & Photobiomodulation Clinic
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Infant Questionnaire
(Adapted from Dr. Kotlow and Dr. Baxter)

Patient's Name_____ Birth Date_____Today's Date_____

__Male __Female __Home Birth __Hospital Birth __Vaginal Birth __ Forcep Birth __ C-section

Medical Problems:_____ Heart Disease:_____ Bleeding Disorders:_____ Other:_____

Physician_____ Phone # _____

Pediatrician_____ Phone # _____

Has your Pediatrician / Physician evaluated your infant's lip or tongue ties? ___Yes ___No __ Agreed __ Disagreed

Lactation Consultant / IBCLC _____ Phone #_____

Referred to our office by: __ internet search __ mommy blogs __Lactation consultant __ Physician __ Pediatrician
__ friend __relative __ Another infant was treated here; Name of referring person_____

Medical History

Infants are usually given Vitamin K at birth to prevent bleeding in the first 8 weeks of life. Did your infant receive the Vitamin K shot? ____Yes ___No
Was your infant premature? __Yes __No If yes, how many weeks? _____
Has your infant had any surgeries? ___Yes ___No
Is your infant taking any medications? ___Yes ___No
Reflux meds ___Yes ___No ; Thrush meds ___Yes ___No ; Other meds __Yes __No
Name of medications_____
Are you presently breastfeeding? ___Yes ___No
If no, how long since you stopped breastfeeding?_____
Are you presently using a nipple shield? ___Yes ___No
Are you choosing not to breastfeed? __Yes __No
Are you pumping breast milk? ___Yes ___No
Are you supplementing using a bottle with formula? ___Yes ___No
Do you or any immediate family members have a bleeding disorders? ___Yes ___No
Has your infant had any prior surgery to correct tongue or lip tie? If yes, when where and by whom?
_____

Signs and Symptoms

Mother

___ Creased, cracked, flatten, or blanching of nipples
___ Blistered, cut, or bleeding nipples
___ Lipstick shaped nipples
___ Infected nipples or breast
___ Poor or incomplete breast drainage (engorged)
___ Mastitis
___ Abraded nipples
___ Nipple Thrush
___ Plugged ducts
___ Feelings of depression (lack of infant-mother bonding)
___ over supply(infant does not require a good latch to receive milk)
___ Under supply of milk
___ Have you had surgery for a breast abscess
Pain when first latching, scale of 1 - 10 _____
Pain during nursing, scale of 1-10 _____
___ Infant unable to achieve a successful, tight latch
___ Baby prefers one side over the other? ___R ___L
___ Frequent feedings (every 45 minutes)
___ Infant gumming or chewing of the nipples

Infant

___ Shallow latch at breast or bottle
___ Falls asleep while nursing
___ Slidesor pops on and off the nipple
___ Unable to keep a pacifier in mouth
___ Reflux symptoms (Aerophagia)
___ Colic symptoms (cries a lot)
___ Spits up often? Amount / Frequencing
___ Clicking or smacking noises when nursing
___ Gagging, choking, coughing when nursing
___ Slow or poor weight gain
___ Upper lip curls under when nursing or taking bottle
___ Pacifier falls out easily, doesn't like it, or won't stay in mouth
___ Milk leaking out sides of mouth during nursing
___ Gagging when attempting to introduce solid foods
___ Short sleep episodes (feeding every 1-2 hours)
___ Gassy (toots a lot)
___ Frustrated at the breast or bottle
___ How long does it take to eat? _____

___ Snoring, heavy breathing
___ Waking up congested after sleeping
___ Sleeps in a tee-pee position (bottom up in the air)
___ Frequent ear infection (every 3 months)
___ mouth breather
___ Runny nose

Dr Lynn Lamont's Laser Dentistry & Photobiomodulation Clinic
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	