INFANT HEALTH HISTORY FORM

Today's Date: _____/_____/_____

YOUR INFANT

Child's Name_____ Date of Birth: _____/_____/_____
Last First

Male: _____ Female: _____

MOTHER ☐ Stepmother ☐ Guardian

Marital Status: ___ Single ___Married
___Divorced ___Widow ___Seperated

Name: _____
Last First

Mailing Address: _____

Physical Address: _____

City_____ State_____ Zip_____

How Long at this address?:_____

Email: _____

Date of Birth: _____/_____/_____ Age: _____

Social Security Number: _____/_____/_____

Home Phone Number: _____/_____/_____

Cell Phone Number: _____/_____/_____

Employer:_____

How Long with this employer?:_____

FATHER ☐ Stepfather ☐ Guardian

Marital Status: ___ Single ___Married
___Divorced ___Widow ___Seperated

Name: _____
Last First

Mailing Address: _____

Physical Address: _____

City_____ State_____ Zip_____

How Long at this address?:_____

Email: _____

Date of Birth: _____/_____/_____ Age: _____

Social Security Number: _____/_____/_____

Home Phone Number: _____/_____/_____

Cell Phone Number: _____/_____/_____

Employer:_____

How Long with this employer?:_____

Insurance: _____ Yes No

Insured Name:_____

Group Number:_____

Insurance Company:_____

ID Number:_____

Insurance Phone #:_____

MEDICAL HISTORY

Child's Physician: _____

Any medical conditions or concerns for your child?:_____

Any medications your child is taking? _____

Any known allergies?: _____ YES _____ NO

If yes, please explain: _____

Any previous surgeries or had frenum clipped previously?: _____ YES _____ NO

Any other information we need to know? _____

By signing below, I acknowledge that I have read and received the Notice of Privacy Practices, as mandated by the Health Insurance Portbility and Accountability Acy of 1996 ('HIPAA')

To the best of my knowledge, I certify that the above information is complete and correct. I understand that it is my responsibility to inform this office of any changes in my childs medical status or any other information provided in this form. I do hereby request and authorize Christensen Orthodontics to examine and perform treatment if necessary for the child named above.

Signature: _____ Date: _____

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Today's Date: _____
Patient Name: _____
Birth Date: _____
Male: ☐
Female: ☐

Mother's Name: _____
Father's Name: _____
City of Residence: _____
Cell Number(s) (for text support):
_____
Email: _____

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1. Are you currently breastfeeding? Yes ☐ No ☐
If no, how long since you stopped breastfeeding? _____
2. Are you choosing not to breastfeed? Yes ☐ No ☐
3. Are you currently using a nipple shield? Yes ☐ No ☐
4. Are you pumping breastmilk? Yes ☐ No ☐
5. Are you supplementing using a bottle and formula? Yes ☐ No ☐
6. Are you using an SNS device? Yes ☐ No ☐
7. Was your infant premature? Yes ☐ No ☐

Mother's Symptoms:

- ☐ Creases, Cracked, Bleeding or Blanching of nipples
- ☐ Flat/ Inverted nipples
- ☐ Painful latching of infant onto the breast
- ☐ Poor or incomplete breast drainage
- ☐ Plugged Ducts
- ☐ Mastitis
- ☐ Feelings of depression
- ☐ Lack of infant-mother bonding
- ☐ Over supply
- ☐ Breast Surgery/ Reduction or Implants
- ☐ Have you had surgery for a breast abcess

Infant's Symptoms:

- ☐ Difficulty in achieving a good firm latch
- ☐ Gumming or chewing of the nipples
- ☐ Falls asleep while attempting to nurse
- ☐ Slides off the breasts when attempting to latch
- ☐ Reflux (clicking, swallowing air during nursing)
- ☐ Slow or poor weight gain
- ☐ Short sleep episodes (feeding every 1-2 hours)
- ☐ Apnea- snoring, heavy noise breathing
- ☐ Unable to keep a pacifier in the infant's mouth
- ☐ Waking up congested in the morning or naptime
- ☐ Only sleeping when held upright, or in a car seat
- ☐ Milk leaking out sides of the mouth during feedings

Physician: _____
Has your physician evaluated your infant's lip and tongue ties? Yes ☐ No ☐ Agreed ☐ Disagreed ☐
Referred to our office by: Internet Search ☐ Lactation Consultant ☐ Physician ☐ Friend ☐ Relative ☐
Another infant was treated here ☐
Name of Referring Person: _____

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Consent for Lingual and/or Labial Frenectomy

DIAGNOSIS: I have been informed of the presence of a frenum that might be exceptionally short, thick, tight, or may extend too far down the gingiva or tongue. When a frenum is tight, it prevents the correct function of the tongue and/or lips. This tissue can be excised with a surgery called a frenectomy or functional frenuloplasty.

PURPOSE OF FRENECTOMY/FRENULOPLASTY 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, sometimes require sutures, and often results in some post-procedure discomfort. The procedure may be performed using a local anesthetic.

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, 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 site of injection 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.

SUPPLEMENTAL RECORDS AND THEIR USE: I consent to photography, filming, recording and x-rays of my oral structures 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 may be 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 successful outcome of my surgery. I agree to follow instructions related to my own daily care of my mouth. I agree to report for appointments following my surgery as suggested so that my healing may be monitored and so that the doctor can evaluate and report on the outcome of surgery upon completion of healing.

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 all procedures related to frenectomy/frenuloplasty surgery as presented to me during the 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. I have read and fully

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understand the terms within this document and give my consent for the proposed treatment described above. I have also been informed of and accept the consequences of refusing treatment.

_____ _____

Patient/Parent Signature Date

_____ _____

Witness Signature Date