Mosaic Dental

KELLY M. GIERA, DDS, PC

TONGUE/LIP TIE PATIENT INFORMATION

Date: ____________________ Infant/Child's DOB: ____________________

Infant/child's Name: ____________________ Gender: ____________________

Parent's Name(s): ____________________

Address: ____________________ City, State, Zip: ____________________

Email: ____________________ Cell Phone: ____________________

Have any other siblings been seen in our office for a Tongue/Lip consult and/or revision? YES / NO

Main Concern: ____________________

Pediatrician: ____________________ Lactation Consultant: ____________________

Is your lactation consultant an IBCLC (Board certified)? YES / NO / Don't Know

Is your child being seen for bodywork (chiropractor, CST, PT, OT, other)? YES / NO

If yes, who are they seeing and how many visits? ____________________

MEDICAL HISTORY

Birth Weight (lb/oz): ____________________ Most current weight and date (lb/oz): ____________________

Allergies: ____________________

List all MATERNAL medications/supplements: ____________________

List all INFANT medications/supplements: ____________________

Was your infant premature? YES / NO If yes, gestational age at birth: ____________________

Does your infant have any heart disease? YES / NO

Has your infant had any surgeries? YES / NO If yes, please list: ____________________

Has your infant had any prior tongue/lip revisions? YES / NO If yes, what was done? ____________________

Does your child have any other medical conditions that we should be made aware of? YES / NO

If yes, please explain: ____________________