Aimee Snell-Killam DDS MS
Ryann McLennan DMD
Pediatric Dentist
www.bigbluedental.com

Tethered Oral Tissues for Infants Questionnaire

Patients Name_____Birthdate_____Todays Date_____
Weeks at Birth_____Current Age_____
Birth Weight_____Current Weight_____
Lactation Consultant_____Last Lactation Appt_____
Pediatrician_____Parents Names_____

Infant Medical and Birth History

Receive Vit K Yes ☐ No ☐
Heart Disease Yes ☐ No ☐_____
Surgery Yes ☐ No ☐_____
Jaundice Yes ☐ No ☐
Reflux Medication Yes ☐ No ☐_____
Allergies Yes ☐ No ☐
Bleeding Problems Yes ☐ No ☐_____
Medications Yes ☐ No ☐_____
Delivery Vaginal ☐ C-Section ☐
Birth Hospital / Midwife_____
Other Important Medical History _____

Previous Surgery to Correct Ties_____By Whom_____When_____
Family History of Tongue or Lip Tie_____
Family history of keloids (thick dense scars) _____
Do you have a history of breastfeeding other children (please describe)_____
_____

Infant Feeding History

How often are you: Nursing_____/day Pumping_____/day Bottle Feeding_____/day

Length of nursing sessions_____Time between feedings_____

Are you using a Nipple Shield Yes ☐ No ☐
Has your feeding been measured by a lactation consultant Yes ☐ No ☐
Amount transferred at last weighted feed Right Side_____Left Side_____

Previous bodywork (Craniosacral Therapy, Chiropractic's, OT, PT etc) Yes ☐ No ☐
If so, who and when_____

-Turn Over-

Please Check All That Apply

Mom's Symptoms

- ☐ Flattened, lipstick shaped or blanched nipples
- ☐ Bruised or blistered nipples
- ☐ Cracked or bleeding nipples
- ☐ Pain when latching Pain 1-10 0
- ☐ Pain once latched Pain 1-10 0
- ☐ Plugged ducts
- ☐ Infected Nipples or breasts / Mastitis
- ☐ Nipple Thrush
- ☐ Nipple Vasospasm
- ☐ Poor or incomplete breast drainage
- ☐ Low supply
- ☐ Strong Letdown or painful oversupply
- ☐ Baby prefers one side over other R / L

Baby's Symptoms

- ☐ Weak, shallow or unable to latch
- ☐ Slides or pops off frequently during feeds
- ☐ Gumming or biting while feeding
- ☐ Clicking or Smacking noises while feeding
- ☐ Spilling milk while feeding
- ☐ Cheeks sucked in while feeding
- ☐ Slow weight gain or weight loss
- ☐ Irritability or Cholic
- ☐ Gas, reflux or excessive spit-up
- ☐ Coughing, choking or gulping while feeding
- ☐ Unable to hold or doesn't like a pacifier
- ☐ Sensitive gag reflex
- ☐ Open mouth breathing
- ☐ Snoring, snorting or noisy breathing
- ☐ Chronic congestion
- ☐ Flutter or quiver of chin
- ☐ Lips curl in during feeding
- ☐ Hiccups often
- ☐ Falls asleep during feeds before full

For Doctors Use Only Below This Line

Clinical Observations:

Finger suction: None / Weak / Normal / Strong Clamp or Bite

Cheek Dimpling / Mentalis Strain / Lip Strain

Tongue movement: Continuous Wave / Short burst with Rest / In and Out / Tremors / Disorganized

Posterior tongue elevation Yes ☐ No ☐

Palate: Flat Normal Arched

Lip

- ☐ Lip callus or blisters, two tone lips
- ☐ Upper lip unable to flange
- ☐ Upper lip unable to elevate to nares
- ☐ Blanching with lifting
- ☐ Tight muscle tone
- ☐ Dip in Lip
- ☐ Alveolar Clefting

Tongue

- ☐ Blisters or sores
- ☐ Tongue unable to elevate
- ☐ Cupping with crying
- ☐ Blanching with lifting
- ☐ Pseudoleukoplakia
- ☐ Speed bump
- ☐ Notched, heart shaped, V shaped
- ☐ Eiffel Tower

Labial Frenum- Class	I	II	III	IV
Thickness	Thin	Thick	Fibrous	Corded
Restriction	Mild	Moderate	Severe	
Lingual Frenum- Class	I	II	III	IV
Thickness	Mild	Moderate	Severe	
Restriction	Mild	Moderate	Severe	

Aimee Snell-Killam DDS MS
Pediatric Dentist
Bigbluedental.com

Infant New Patient

Today's Date_____

1 Tell Us About Your Child

Full Name_____
Nickname_____ ☐ Male ☐ Female
Date of Birth ___/____/_____

2 Parent/Guardian/Guarantor Information

Full Name_____
Relationship to Child_____
Date of Birth _____ SSN_____
Address_____
City_____ State_____ Zip_____
Employer_____
Drivers License #_____

3 Parent/Guardian Information

Full Name_____
Relationship to Child_____
Date of Birth _____ SSN_____
Address_____
City_____ State_____ Zip_____
Employer_____
Drivers License #_____

4 Best Contact Information

Phone_____
Email_____

Do you give permission to text and email you regarding your child's treatment including photographs? ☐ Y ☐ N

Do you give permission to release information regarding your child's treatment including photographs to your child's other health care practitioners? ☐ Y ☐ N

5 How Did You Hear About Us?

_____

6 Dental Insurance

Insurance Co Name_____
Address_____
Phone (____)_____
Group # (Plan, Local or Policy #)_____
Policy Owner's Name_____
Policy Owner's SSN_____
Policy Owner's Date of Birth_____
Policy Owner's Employer_____

7 Secondary Dental Insurance

Insurance Co Name_____
Address_____
Phone (____)_____
Group # (Plan, Local or Policy #)_____
Policy Owner's Name_____
Policy Owner's SSN_____
Policy Owner's Date of Birth_____
Policy Owner's Employer_____

8 Emergency Contact

Name_____
Phone_____

Do you give permission to use photos/videos taken of your child for educational purposes such as (but not limited to) lectures, presentations, instructional videos or pamphlets, web content? ☐ Y ☐ N

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for standard and proper care. I authorize the release of any information concerning my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits and to other health care professionals. I hereby authorize payment of insurance benefits directly to Big Blue Pediatric Dentistry, otherwise payable to me. I understand that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental insurance. I attest to the accuracy on this page.

Signature _____ Date_____

Big Blue
pediatric dentistry

Aimee Snell-Killam DDS , MS
Pediatric Dentist
www.bigbluedental.com

Financial Policy

Thank you for choosing Big Blue Pediatric Dentistry for your child's treatment. Please feel free to ask if you have any questions. Good communication about financial responsibilities promotes good relationships.

*The legal guardian who accompanies the child is legally responsible for payments

We participate with multiple dental insurance companies. You are ultimately responsible for understanding your benefits, however, we do make every effort to help if you have any questions.

If your child does not have dental insurance, their medical insurance may cover some procedures. As we are not contracted with medical insurance companies, it is your responsibility for payment in full at the time of service. We will provide codes and narratives which you may be able to submit to your insurance and receive reimbursement.

*Payment is due at the time of service _____ (Initials)

Any remaining balance after 45 days must be paid in full. We accept cash, checks and all major credit cards.

Parent Signature_____ Date_____

Acknowledgement of Receipt of Notice of Privacy Practices

*You may refuse to sign this acknowledgement

I, _____, have received a copy of this Office's Notice of Privacy Practices.

Signature _____ Date_____

1789 East College Pkwy, Suite 121 Carson City, NV 89706
Tel. (775) 887-9453
Fax (775) 887-1915