Family Dentistry
Annette Skowronski, DDS, FAGD, PC

Lip Class: _____
Tongue Class: _____

Patient Information

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Birthdate _____ Gender: M___F___Email: _____
Birth Weight_____ Current Weight_____
Home Phone (___)_____Cell Phone (___)_____ Work Phone (___)_____
Do you prefer to receive calls at: Home_____Work ____Cell _____
Name of person responsible for this account and relationship to patient _____
Parents names (both mom and dad) _____
Address if different from patient's _____
Contact phone number if different from patient's (___)_____

Referral Information

Whom may we thank for referring you to our practice? _____

I acknowledge that I have received the "Notice of Privacy Practices" from the office of Dr. Annette Skowronski.

Signature: _____ **Date:** _____

Mother Please Circle all that applies:

- **A.** Painful feeding
- **B.** Bruised, cracked, blistered, flattened or bleeding nipples
- **C.** Breast swelling
- **D.** Mastitis
- **E.** Thrush of the nipples
- **F.** Use nipple shield to breastfeed

How many times daily do you breastfeed? _____

Delivery:

Full term: _____ **Early (premature):** _____
Vaginal: _____ **C-Section:** _____

Pumping: Y/N **Pumping after feeding: Y/N**
Quantity/day: _____ **Stored breastmilk: Y/N**

History of anyone in your family with a lip or tongue tie? _____
Family History of bleeding disorders? Y/N
If yes please explain: _____
Additional information regarding your health that should be considered: _____
_____

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Infant Please circle all that applies to your child:

- **A.** Prolonged nursing, if so how long are sessions? _____ minutes
- **B.** Incomplete nursing
- **C.** Baby falls off the breast and sleeps
- **D.** Lip or tongue feels weak
- **E.** Baby slides off the nipple
- **F.** Chronic burping or flatulence
- **G.** Distended or bloated belly
- **H.** Signs of reflux such as chronic spitting up or vomiting
- **I.** Signs of discomfort such as arching of back or clenching of the hands
- **J.** Clicking noises while nursing
- **K.** Lip or tongue cycles through sucking and movement for a short time then stops and recycles

Have you consulted with a Lactation Consultant? Y/N
If yes, what is the name, phone # and fax # of the Lactation Consultant?
Name: _____ Phone #: _____ Fax #: _____

Is this your first child? Y/N
If this is not your first child did you breastfeed your other child/children? Y/N
How long did you breastfeed your other children? _____
Has your child had Craniosacral (CST) or Chiropractic Care? Y/ N
Are there signs of gagging? Y/N
Is your baby losing weight? Y/N
Do you supplement with a bottle to assist with proper feeding? Y/N Formula? Y/N
Is your child able to hold a pacifier? Y/N

Additional information regarding your child's health that should be considered:

_____

Pediatrician's name: _____

Phone: _____ Fax: _____

Pediatrician's Address: _____

Medications: _____ Allergies: _____

Signature _____ Relationship _____ Date _____

Reviewed by _____ Date _____