Wiechart Dental Intake Form

Today's Date: Date of Birth:

Patient Name: Gender:

Birth Weight: Current Weight:

Birth Hospital:

Lactating Parent's Name: Partner's Name:

Phone/cell#:

Birth: Vaginal or C-Section Birth

Complications:

Are you presently breastfeeding? ☐ YES ☐ NO

If no, how long since you stopped breastfeeding?

Medical History

Infants are usually given Vitamin K at birth.

Did your child receive the vitamin K shot? ☐ YES ☐ NO

Was your infant premature? ☐ YES ☐ NO

Does your infant have any heart disease? ☐ YES ☐ NO

Does your infant have any bleeding disorders? ☐ YES ☐ NO

Has your infant had any surgeries? ☐ YES ☐ NO

If yes, how many weeks?

Does your infant have any medical issues? If so, please explain:

Infant Symptoms

- ☐ Shallow latch at breast or bottle
- ☐ Painful Nursing
- ☐ Reflux or frequent spit up
- ☐ Clicking/smacking noises when eating
- ☐ Gagging, choking, coughing when eating
- ☐ Slow or poor weight gain
- ☐ Milk dribbles out of mouth when nursing
- ☐ Snoring, noisy breathing or mouth breathing
- ☐ Prolonged feeding time at breast or bottle
- ☐ Baby is frustrated at the breast or bottle
- ☐ Gassy/Fussy often
- ☐ Lip curls under when nursing or taking bottle

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How long does baby take to eat? _____ How often does baby eat? _____

How many wets in 24 hours? _____ Stools? _____

Is your infant taking any medications? ☐ YES ☐ NO

If Yes, Name of medication? _____

Reflux? ☐ YES ☐ NO Thrush? ☐ YES ☐ NO

Has your infant had a prior surgery to correct the tongue or lip tie? ☐ YES ☐ NO

If yes, when, where and by whom?

_____

Has your infant had any bodywork (PT, OT, Chiropractic, Cranial Sacral Therapy, Massage, etc.)? ☐ YES ☐ NO

Parent Signs or Symptoms

- ☐ Creased, flattened or blanched nipples
- ☐ Lipstick shaped nipples
- ☐ Damaged nipples (blisters, bruising)
- ☐ Using a nipple shield
- ☐ Poor or incomplete breast drainage
- ☐ Plugged ducts/engorgement/mastitis
- ☐ Nipple Thrush
- ☐ Baby prefers one side over other? R/L

Pain (1-10) during nursing? _____

Pediatrician: _____ Fax Number: _____

Lactation Consultant: _____ Fax Number: _____

Who referred you to us? _____

Please e-mail completed please form to: office@wiechartdental.com