FOR OFFICE USE: Appt: Time and Date		

FRENULECTOMY IN-TAKE FORM (OVER 12 MONTHS OF AGE)

Patient's Name:		**Date:**	
Allergies		**DOB:**	
Medical History:		Sex:	

FEEDING HISTORY/AREAS OF CONCERN /SPEECH ISSUES
(ie. Poor latch, falling off, low weight gain, colic, GERD, clicking, nursing discomfort, etc.)

Child:

Previous Tongue Tie Revision? If Yes, when was the previous revision completed?

Date:	Provider:

Parent / Guardian Information

Primary Email:			
PARENT'S FULL NAME:			
Street Address:		**Phone:**	
City, State:		**Zip Code:**	
Parent's Full Name:			
Street Address:		**Phone:**	
City, State:		**Zip Code:**	

Referral Source:

Lactation Consultant / Pediatrician / Speech or Feeding Specialist:

PHONE #:			
Other:		**Organization:**	

If possible, please attach photos of your child's upper lip, with it reflected up toward the nose to see the upper lip frenum and the area under the tongue, with the tongue reflected up towards the roof of the mouth.	