CASCADIA KIDS DENTISTRY

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FRENOTOMY CONSULTATION

Child's Name ____ Birthdate _______________________ M / F

Parent(s)/Guardian(s) Name ____

Please check *any* of the following that apply:

Infant Factors

- ❑ Ineffective latch-on
- ❑ Un-sustained latch-on
- ❑ Slides off nipple
- ❑ Prolonged feeding times
- ❑ Unsatisfied hunger after feedings
- ❑ Falling asleep on the breast
- ❑ Gumming or chewing of the nipple
- ❑ Poor weight gain or failure to thrive
- ❑ Unable to hold pacifier
- ❑ Cancer, tumors, other growths
- ❑ Gas, colic, or reflux

Other Concerns:

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Other Therapies Attempted or Completed:

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