DR. PAIGE PRATHER
LIP-TIE & TONGUE-TIE SOLUTIONS

PEDIATRIC PATIENT HISTORY

Patient Name: _____ **Gender**: Male Female

Date of Birth: _____/_____/_____ **Birth Weight:** _____ lbs _____ oz Current Weight: _____ lbs_____oz

Name of Mother: _____ **Name of Father**: _____

Delivery: □ Vaginal □ Cesarean **Was this child premature?** _____ How many weeks? _____

Were there problems with this child's delivery? _____ If so, please list: _____

Did this child have any unusual problems in the hospital such as trouble breathing, blue spells, yellow jaundice, trouble feeding, etc?

_____

Did this child need special treatment while in the hospital such as oxygen, transfusions, or lights? _____

Is this child breast feeding? Y N **Did/Does this child have any problems with breast feeding or formula feeding?** _____

Current Milk Intake: Type: _____ Amount (oz/day): _____ **Does this child suck a finger, thumb or pacifier?** _____

Are you currently seeing a Lactation Consultant? Y N **If so, who?** _____

Please mark all of the following that this child has been treated for:

□ Heart Disease	□ Bleeding/Transfusions	□ Asthma/Trouble Breathing	□ Mental Delays
□ Liver/GI Disease	□ Anemia	□ Hepatitis	□ Physical Delays
□ Kidney Disease	□ Rheumatic Fever	□ Cleft Lip/Palate	□ Adverse Drug Reactions
□ Speech/Hearing	□ Seizures	□ Frequent Infections	□ Autism
□ Eyesight	□ Congenital Birth Defects	□ Endocrine/Growth	□ Other Problems: _____
□ Cancer/Tumors	□ Significant Injuries	□ Blood Dyscrasias	_____
□ Cerebral Palsy	□ Diabetes	□ AIDS	

Does this child have any of the following?

□ Lung Problems	□ Heart Problems	□ Kidney/Urinary Problems	□ Bone/Muscle Problems
□ Gastro-Intestinal Problems	□ Brain/Nervous System Problems	□ Skin Problems	□ Eye/Ear/Nose/Throat Problems

Has this child ever had a reaction to or problem with an anesthetic? Y N **Describe:** _____

Is this child up to date on immunizations against childhood diseases? Y N **Did this child receive Vitamin K at birth?** Y N

Recent Hospitalizations or Surgeries: _____

Please list all known drug allergies: _____

Do any immediate family members have a history of bleeding or clotting disorders? If so, who? _____

Please list any regular medications (over the counter or prescription) and include dose and frequency: _____

_____

Any other medical issues we should be aware of: _____

Name of Pediatrician: _____ **Phone:** _____**Date of last physical exam:** _____

To the best of my knowledge, this information is true and correct. I know if there are any changes in my child's health, it is my responsibility to inform my child's provider.

Print Patient Name: _____

Print Name of Parent/Guardian: _____ **Relation**: _____

Signature of Parent/Guardian:_____ **Date**: _____

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AUTHORIZATION OF RELEASE

We are so happy that you trust us with the care of your little one. As a courtesy to your current providers we send follow up letters to your lactation consultant and pediatrician.

Patient Name: _____ Date of Birth: _____

Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical/dental and or billing information released to your providers, you must sign this form.

I authorize Paige Prather Smiles to release my medical/dental and or billing information to the following:

Lactation Consultant name: _____

Phone: _____

Email: _____

Pediatrician office: _____

Phone: _____

Email: _____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclose.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature: _____ Date:_____