Child Tongue/Lip Tie Questionnaire

Patient's Name_____ Birthday_____ Age_____ Today's Date_____

Medical Issues: _____ Medications taking: _____

Allergies: _____ Previous clip or release of tongue/lip? _____(date)

1. Has your child experienced any of the following issues? Please circle or elaborate as needed.

Speech

__Frustration with communication
__Difficult to understand by parents
__Difficult to understand by outsiders
__% Percent of time you understand your child
__Difficulty speaking fast
__Difficulty getting words out (groping for words)
__Trouble with sounds (which?)_____
__Speech delay (when?)_____
__Stuttering
__Speech harder to understand in long sentences
__Speech therapy (how long)_____
__Mumbling or speaking softly
__"Baby Talk"

Nursing or Bottle-Feeding Issues as a Baby

__Painful nursing or shallow latch
__Poor weight gain
__Reflux or spitting up
__Unable to hold pacifier
__Milk dribbling out of mouth
__Poor supply
__Nipple shield required for nursing
__Clicking or smacking noise when eating
__Other:_____

Sleep issues

__Sleeps in strange positions
__Kicks and flails around at night
__Wakes easily or often
__Wets the bed
__Wakes up tired and not refreshed
__Grinds teeth while sleeping
__Sleeps with mouth open
__Snores while sleeping (how often?)_____
__Gasps for air or stops breathing (sleep apnea)

Pediatrician_____
Speech Therapist/Chiropractor_____
Who referred you to us? _____

Feeding

__Frustration when eating
__Difficulty transitioning to solid foods
__Slow eater (doesn't finish meals)
__Grazes on food throughout the day
__Packing food in cheeks like a chipmunk
__Picky eater / with textures (which?)_____
__Choking or gagging on food
__Spits out food
__Won't try new foods
__Other: _____

Other Related Issues

__Neck or shoulder pain or tension
__TMJ pain, clicking or popping
__Headaches or migraines
__Strong gag reflex
__Mouth open/mouth breathing during the day
__Tonsils or adenoids removed previously
__Ear tubes previously
__Reflux (medicated or not)
__Hyperactivity / Inattention
__Constipation
__Thumb sucking (previous or present)

Anything else we need to know?

_____

_____

_____

_____

DE PERE SMILES s.c.

For the office: _____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice. Please fill out the following information.

Persons involved in Care: By signing this form, you will consent to our use of your dental care records to the following persons, including those involved in your care or payment for that care. Please list the person(s) you would like involved in your care or payment for that care.

_____ _____

_____ _____

_____ _____

Print Name_____ Signature _____Date_____

Financial Policy:

A 5% courtesy discount: For established patients at time of service – payments made by cash, check, HSA, or qualifying debit cards (Visa, Mastercard, or Discover).

Credit Card: We accept Visa, Mastercard, and Discover credit cards (no 5% discount).

Established good credit: We will bill you. Payment in full is expected within 21 days of statement date.

Treatment plans exceeding $1500:

1. If you have dental insurance – Pre-treatment estimate must be completed prior to commencement of treatment.
2. If you DO NOT have dental insurance OR if insurance will not provide benefits for the planned procedure(s) – Credit card or debit card must be on file for automatic monthly deduction prior to start of treatment. We accept Care Credit cards; ask us about details.

**Default of payment: Any balances not paid in full within 60 days from date of transaction will result in a 1.5% monthly finance charge. If delinquent payments continue, the account may be turned over to a collection agency and patient(s) will be dismissed.

Financial Responsibility:

Children under 18: The parent/legal guardian who brings in the child is responsible for payment.

Divorce/Separation: Please notify office staff immediately so accounts can be separated for future billings.
**Accounts cannot be separated until the outstanding balance is paid.

Patients over age 18: If a dependent, we will bill the parents. If someone is under legal guardianship it is necessary for the guardian to sign forms. Patients are responsible for all charges incurred.

**We feel it is important to keep you informed of your treatment costs. At any time you may request a treatment plan estimate. Please keep in mind certain circumstances may alter treatment or fees.

Insurance Policy

We are happy to file the necessary forms to help you receive the full benefits of your coverage(s); however we make no guarantee of any estimated coverage or payment. Because insurance is an agreement between you and your insurance company, all patients are responsible for all charges.
**Secondary insurance does not coordinate benefits on pre-estimates.

Broken Appointment Policy

Our patients are very important to us. When there is a broken appointment another patient is denied the opportunity for treatment. We therefore require a minimum 24 hour or one full working day notification to cancel appointments (whichever is greater). Failure to do so will result in:

1st time: Warning and $50 charge
2nd time: Patient Dismissal

I have read and agree to the previously listed policy:

Signed:_____ Date:_____

If under age 18, Guarantor Signature:_____ Date:_____

Infant/Child Frenectomy Parent Consent

I acknowledge that the doctor has explained my child's condition and the proposed frenectomy procedure. I understand the risks of the procedure, including the risks that are specific to my child and the likely outcomes. I was able to ask questions and raise concerns with the doctor about my child's condition, the procedure and its risks, and treatment options. My questions and concerns have been discussed and answered to my satisfaction. I understand that photographs or video footage may be taken during my child's procedure and these may be used for educational or marketing purposes. (Your child will not be identified in any photo or video). I understand that no guarantee has been made that the procedure will improve the condition and that the procedure may make my child's condition worse. On the basis of the above statements, I REQUEST THAT MY CHILD HAS THE PROCEDURE.

Name of Patient AND Parent: _____

_____

Signature of Parent/Substitute decision maker:

_____ Date:_____

For the Office:_____

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