Infant Tongue / Lip Tie Questionnaire

Parent and infant's name: ____ Birthdate: _________________
Male_____ Female_____ Birth weight __________________ Present weight _____________________
Birth: _____Home birth _____Hospital birth _____Vaginal birth _____C-section birth
Are you presently breastfeeding? _____yes _____no If no, how long since you stopped? ____________
Parent's Name: ____

Medical History: Has your child experienced any of the following problems or treatment?

1. *Infants are usually given vitamin K at birth to prevent bleeding in the first 8 weeks of life. Did you sign any waiver to refuse the administration of vitamin K?* ____yes ____no
2. Does your infant have any *bleeding disorders*? ____yes ____no
3. Was your infant born *premature*? ____yes ____no
4. Does your infant have *heart disease*? ____yes ____no
5. Has your infant had *any surgery*? ____yes ____no
6. Does your infant have any *allergies*? ____yes ____no
7. Has your infant had a prior surgery to correct the tongue or lip tie? ____yes ____no
8. Is your infant taking any *medications*? ____yes ____no List ____________________________________
9. Has your infant taken any pain medication today? ____yes ____no
10. Is it ok to give your infant pain medication today? ____yes ____no

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Has **your infant** had any of the following?

YES / NO

- ☐ ☐ Poor latch
- ☐ ☐ Falls asleep while attempting to nurse
- ☐ ☐ Slides off nipple when trying to latch
- ☐ ☐ Colic symptoms
- ☐ ☐ Reflux symptoms (due to excessive clicking or air intake)
- ☐ ☐ Poor weight gain
- ☐ ☐ Gumming/chewing nipple when nursing
- ☐ ☐ Unable/unwilling to take pacifier
- ☐ ☐ Short sleep episodes requiring feeding every 1-2 hours

Pediatrician_______________________________
Phone number_____________________________
Address___________________________________
City___________________State____Zip______

Do **you** have any of the following?

YES / NO

- ☐ ☐ Creased, flattened or blanched nipples after nursing
- ☐ ☐ Cracked, bruised, or blistered nipples
- ☐ ☐ Bleeding nipples
- ☐ ☐ Severe pain when your infant attempts to latch
- ☐ ☐ Poor or incomplete breast drainage
- ☐ ☐ Infected nipples or breasts
- ☐ ☐ Plugged ducts or mastitis
- ☐ ☐ Nipple thrush

***Patient MUST be evaluated by a lactation consultant prior to being seen by Dr. Peterson.

Lactation consultant_______________________
Phone number_____________________________
Address___________________________________
City___________________State____Zip______

**I certify that the information provided on this form is correct to the best of my knowledge.

____
Parent or Guardian's Signature

DS DE PERE SMILES s.c.

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.

<u>Persons involved in Care:</u> 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 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:_________________