

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 mark and 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?



For the office: _____

Financial Policy

Patients with Dental Insurance

We are happy to file the necessary forms to help you receive the full benefits of your insurance; 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.

*Important: we are not a Medicaid certified office. We cannot submit claims to Medicaid and patients with Medicaid are expected to pay their balance, in full, on the day of the service.

****Patient portion is expected in full at time of service.**

Patients without Dental Insurance

Payment is expected in full at time of service.

For established patients without insurance at time of service – payments made by cash, check, HSA, or qualifying debit cards may qualify you for a 5% discount. Not all of our services qualify for this discount (tongue/lip tie releases do not qualify).

Financial Responsibility

For patients under the age of 18, parent/legal guardian who brings in the child is responsible for payment.

For dependents over the age of 18, parent(s) are responsible for payment. If someone is under legal guardianship it is necessary for the guardian to sign forms.

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.

Any balances not paid in full within 30 days from date of transaction will result in a 1.5% monthly finance charge and/or will be sent to collections. We reserve the right to dismiss any patient for default of payment.

Credit Card

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

Cancellation Policy

We require a 24-hour notice for cancellations.

Failure to do so will result in a \$50 charge and/or patient dismissal.

If patient fails to show for first visit, patient will be automatically dismissed.

Patient / Parent or Guardian's Signature _____ Date _____



Personal Health Information Form

The Department of Health and Human Services has established a "Privacy Rule" to help ensure 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.

List names of who may have access to patient's medical information:

Patient / Parent or Guardian's Signature _____ Date _____



Infant/Child Frenectomy Parent Consent

I acknowledge that the doctor has explained my child's condition and the proposed frenectomy procedure(s). I understand the risks of the procedure(s), 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(s) will improve the condition and that the procedure(s) may make my child's condition worse. On the basis of the above statements, I REQUEST THAT MY CHILD HAS THE PROCEDURE(S).

Name of Patient AND Parent: _____

Signature of Parent/Substitute decision maker:

_____ Date: _____

For the Office: _____

