Infant Tongue / Lip Tie Questionnaire

Parent and Infant's names: _____ Infant's DOB: _____
Male_____ Female_____ Birth weight _____ Present weight _____
_____Home birth _____Hospital birth _____Vaginal birth _____C-section birth
Are you presently breastfeeding? _____yes _____no If no, how long since you stopped? _____

Medical History: Has your child experienced any of the following problems or treatment?
1. Did your baby receive vitamin K injections? ____yes ____no *(Infants are usually given vitamin K at birth)*
2. Does your infant have any *bleeding disorders*? ____yes ____no
3. Is there a *family history of bleeding disorders*? ____yes ____no
4. Was your infant born *premature*? ____yes ____no
5. Does your infant have *heart disease*? ____yes ____no
6. Has your infant had *any surgery*? ____yes ____no List _____
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 _____

Infant Symptoms (check all that apply)

____ Shallow latch at breast or bottle
____ Falls asleep while eating
____Slides or pops on and off the nipple
____ Colic symptoms / Cries a lot
____ Reflux symptoms
____ Clicking or smacking noises when eating
____ Spits up often
____ Gagging, choking, coughing when eating
____ Gassy often
____ Poor weight gain
____ Hiccups often
____ Lip curls under when nursing or taking bottle
_____Gumming or chewing your nipple when nursing
_____Pacifier falls out easily, doesn't like, won't stay in
_____ Milk dribbles out of mouth when nursing/bottle
_____ Short sleeping requiring feedings every 1-2hrs
_____Snoring, noisy breathing or mouth breathing
_____Feels like a full-time job just to feed baby
_____ Nose congested often
_____ Baby is frustrated at the breast or bottle
How long does baby take to eat? _____
How often does baby eat? _____

Mother Symptoms (check all that apply)

____ Creased, flattened or blanched nipples
____ Lipstick shaped nipples
____ Bleeding / blistered / cut nipples
Pain on a scale of 1-10 when first latching _____
Pain (1-10) during nursing: _____
____ Poor or incomplete breast drainage
_____ Infected nipples or breasts
_____Plugged ducts / engorgement / mastitis
_____Nipple thrush
_____ Using a nipple shield
_____Baby prefers one side over other (R/L)

Pediatrician _____

Lactation Consultant _____

Who referred you to us? _____

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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 _____

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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 _____

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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:_____

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