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PATIENT REGISTRATION

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

SEX: ❑ Male ❑ Female D.O.B: _____

RESPONSIBLE PARTY(If someone other than the patient)

Relationship to Patient: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ SSN#: _____

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

Email Address: _____

DENTAL INSURANCE INFORMATION

Name of Policyholder: _____

Relationship to Policyholder: ❑ Self ❑ Spouse ❑ Child ❑ Other

Policyholder's SSN#: _____

Policyholder's Date of Birth: _____

Insurance Company: _____

Member ID Number: _____

Plan/Group Number: _____

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TONGUE/LIP TIE PATIENT REGISTRATION

Patient's Name: _____ Parent's Names: _____

Patient's DOB: _____ Pediatrician's Name: _____

Hospital/Place of delivery: _____

Are you currently working with a lactation consultant? ❑ Yes ❑ No

If so, who? _____ Where? (hospital/private) _____

Is your infant currently being seen for bodywork (chiropractor, physical therapist, osteopath, occupational therapist, other)? ❑ Yes ❑ No

If yes, what type and by whom? _____

MEDICAL HISTORY

Birth weight (lb/oz): _____ Most Current weight and date (lb/oz): _____

Food allergies? ❑ Yes ❑ No If yes, which food(s): _____

Medication allergies? ❑ Yes ❑ No If yes, which medication(s): _____

List all current infant medications/supplements: _____

Was your infant premature? ❑ Yes ❑ No If yes, gestational age at birth: _____

Did your infant recieve a vitamin K shot? ❑ Yes ❑ No

Does your infant have any heart disease? ❑ Yes ❑ No

Has your infant had any surgeries? ❑ Yes ❑ No If yes, what type(s) and when: _____

Has your infant had prior surgery to correct a tongue or lip tie? ❑ Yes ❑ No

If yes, please specify which area(s) of the mouth and who preformed the procedure: _____

_____

Does your child have any other medical conditions? ❑ Yes ❑ No

If yes, please explain: _____

_____

PREGNANCY/LABOR HISTORY

Please check any that applied:

❑ Long Labor/Excessive Pushing ❑ Breech Birth ❑ Unplanned C-Section ❑ Trauma from Vacuum or Forceps

If you have any other labor complication(s), please explain: _____

_____

MODE OF FEEDING

Is this your first time breastfeeding? ❑ N/A ❑ Yes ❑ No Are you currently using nipple shield? ❑ Yes ❑ No

How would you rate your milk supply? ❑ Oversupply ❑ Good ❑ Fair ❑ Poor

Are you supplementing with pumped breast milk? ❑ Yes ❑ No On average, how long does it take to feed your child? _____ min.

Are you supplementing with formula? ❑ Yes ❑ No Have you done any pre- and post-feeding weight checks? ❑ Yes ❑ No

BABY'S SYMPTOMS

Does your infant pop on and off the breast or bottle while feeding?	❑ Yes ❑ No
Does your infant struggle to stay awake while nursing?	❑ Yes ❑ No
Does milk or formula leak or spill out the side of the mouth while actively feeding at breast or bottle?	❑ Yes ❑ No
Does your infant have a history of poor weight gain?	❑ Yes ❑ No
Does your infant chomp and gum on your nipples while feeding?	❑ Yes ❑ No
Does your infant become fussy or fight you at the breast?	❑ Yes ❑ No
Does your infant's upper lip remain tucked in while feeding at breast or bottle?	❑ Yes ❑ No
Is your infant very gassy?	❑ Yes ❑ No
Has your infant been diagnosed with GERD (reflux)?	❑ Yes ❑ No
Is your infant experiencing colic?	❑ Yes ❑ No
Do you hear a "clicking" noise while feeding?	❑ Yes ❑ No
If yes, is it frequent?	❑ Yes ❑ No
Does your infant use a pacifier?	❑ Yes ❑ No
If yes, does it frequently pop out?	❑ Yes ❑ No

MOTHER'S SYMPTOMS

Using a scale from 0-10, with 10 being the highest, how would you rate your discomfort while breastfeeding?

Please check any of the following that best describes your breasts or nipples after feeing (*B=Both/ R=Right/ L=Left):*

	B	R	L		B	R	L
Creased	❑	❑	❑	Cracked	❑	❑	❑
Flattened	❑	❑	❑	Bruised	❑	❑	❑
Lipstick-Shaped	❑	❑	❑	Blistered	❑	❑	❑
Blanched White	❑	❑	❑	Bleeding	❑	❑	❑

Are you experiencing poor or incomplete breast drainage?	❑ Yes ❑ No
Do you have a history of, or currently have, mastitis?	❑ Yes ❑ No
Do you have a history, or currently have, nipple/infant oral thrush?	❑ Yes ❑ No

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CONSENT FOR FRENECTOMY

DIAGNOSIS:

After an oral examination of my (or my child's) mouth, I have been advised that the examination demonstrates abnormal tension or shortened bands related to the tongue, central upper lip or other areas in the mouth and that these bands may be related to symptoms being experienced.

RECOMMENDED TREATMENT:

In order to treat this condition, the doctor has recommended a procedure to release the tight bands (Frenectomy).

PRINCIPAL RISKS AND COMPLICATIONS:

I understand a small number of patients experience problems after the procedure.

Risks include:

- Pain
- Bleeding(especially if vitamin K has not been administered)
- Infection
- Numbness
- Damage to saliva glands(resulting in blockage or ranula) and/or saliva ducts
- Damage to underlying structures(i.e: muscle and nerve fibers, blood vessels, etc.)
- Aversion to any feeding
- Reattachment of the bands causing return of symptoms
- Failure to improve
- Need for repeat surgery or other surgeries(to treat completely).

NECESSARY FOLLOW-UP CARE AND SELF-CARE:

I understand that failure to failure to follow recommendations could lead to ill effects, which is my sole responsibility. I know it is important to abide by the specific instructions given by the doctor. Continued involvement with your lactation consultant, Chiropractor my functional therapist or other health care professional is mandatory and critical in improving symptoms.

I have asked all of my questions and have had time to discuss options with my dental surgeon.

By signing, I elect to proceed with the procedure for myself (or my child).

Patiens Name: _____

Parent/Guardian Signature: _____

Date: _____

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PATIENT HIPPA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice at any time and that I may contact Dental Health Associates at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed: _____ **Date:** _____