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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: _____

Today's Date: _____ Patient's DOB: _____

What are the main concerns that brought you in today? _____

PATIENT'S SYMPTOMS

Is the patient undergoing any type of therapy for the concerns or issues mentioned above? ❑ Yes ❑ No

If yes please specify which type(s) of therapies and the names(s) of the providers:

_____

Has the patient been previously treated for a tongue and/or lip tie? ❑ Yes ❑ No

If yes, please specify:

_____

When and Where:

_____

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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:** _____