TONGUE/LIP TIE PATIENT INFORMATION

Today's Date: ______________________ Patient's DOB: ______________________

Patient's Name: ______________________ Parent's Name(s): ______________________

Main Concerns: ______________________

____

____

Pediatrician's Name: ______________________

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

Is 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 maternal medications/supplements: ______________________

List all current infant medications/supplements: ______________________

Was your infant premature? ❍ Yes ❍ No If yes, gestational age at birth: ______________________

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 the tongue or lip tie? ❍ Yes ❍ No

If yes, what type(s) and where: ______________________

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

If yes, please explain: ______________________

PREGNANCY/LABOR HISTORY: Normal or High Risk (please circle)

Were there any additional stressors with labor? ❍ Yes ❍ No

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

Other (please explain): ______________________

Difficulty with latch after birth? ❍ Yes ❍ No If yes, please explain: ______________________

MODE OF FEEDING

Is this your first time breastfeeding? ❍ N/A ❍ Yes ❍ No

Other breastfed children/how long? ______________________

Are you supplementing with pumped breast milk? ❍ Yes ❍ No

If yes, how many bottles/ounces per day? ______________________

Are you supplementing with formula? ❍ Yes ❍ No

If yes, how many bottles/ounces per day? ______________________

Are you using SNS or any other supplementer? ❍ Yes ❍ No

Are you currently using a nipple shield? ❍ Yes ❍ No

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

On average, how long does it take to breastfeed your child? ________ min.

Have you done any pre- and post-feeding weight checks? ❍ Yes ❍ No

If so, how much was transferred? ________ oz.

TONGUE/LIP TIE PATIENT INFORMATION

BABY'S SYMPTOMS

Does your infant pop on and off the breast/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/bottle?	❍ Yes ❍ No
Is your infant very gassy?	❍ Yes ❍ No
Does your infant cough or choke during or after feeding?	❍ 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 frequenttly pop out?	❍ Yes ❍ No

MOTHER'S SYMPTOMS

Please rate your level of discomfort while feeding or when you did breastfeed:

N/A None Very Low Low Medium High Very High

Please check any of the following that best describes your breasts or nipples after feeding. Also indicate which breast you are noticing the issues:

R=Right | L=Left | B=Both	❍ Creased R | L | B	❍ Flattened R | L | B	❍ Lipstick-Shaped R | L | B	❍ Blanched White R | L | B
❍ Cracked R | L | B	❍ Bruised R | L | B	❍ Blistered R | L | B	❍ Bleeding R | L | B	❍ Normal

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 of, or currently have, nipple/infant oral thrush?	❍ Yes ❍ No

In a sentence or two, please share your breastfeeding/feeding goals or other concerns:

____

____

Who may we thank for referring you to our office?

____

____

FOR DOCTOR USE ONLY

	Type	Rec Tx
Lip	1, 2, 3, 4	Y/N
Tongue	1, 2, 3, 4	Y/N

Dr. Initials:____________________

CONSENT FORM

DIGITAL MEDIA CONSENT

I/we, ____, the parent(s)/guardian(s) of

(child's full name)____ , hereby give Newman Family Dentistry permission to use any still and/or moving images, including video footage, photographs and audio footage depicting my/our child named above for the following uses:

- Advertisements, marketing, leaflets, or any other use such as training, educational or publicity purposes

Signed: ____Date:______________________________

Signed: ____Date:______________________________

INFORMED CONSENT

The **lingual frenectomy/frenotomy** is a minor surgical procedure that involves clipping and/or lasering the band of tissue located on the underside of the tongue (frenum or frenulum). When this band is too tight, too short, or both, normal tongue movement is prevented.

The treatment may accomplish the following, but not be limited to:

- Allow the tongue to move in a greater range of motion
- Possibly improve breastfeeding comfort
- Possibly improve breastfeeding efficiency
- Possibly reduce the severity of speech difficulties

Complications of this treatment may include, but not be limited to:

- Excessive bleeding
- Damage to the vital structures under the tongue
- No perceivable benefit may be achieved

The **labial frenectomy/frenotomy** is a minor surgical procedure to free the lip attachment from the gums when it is too tight and/or too short. It can restrict proper lip movement and flexibility.

The treatment may accomplish the following, but not be limited to:

- Allow adequate lip flange to improve nursing effectiveness
- Reduce the pockets on either side of the frenum to prevent food trapping
- Give the upper lip more freedom of movement for speech sounds
- Possible reduction in reflux/aerophagia

Complications of this treatment may include, but not be limited to:

- Excessive bleeding
- Lip muscle damage
- No perceivable benefit may be achieved

Please note that this treatment is NOT intended to prevent a gap between the upper front teeth. If that is the goal, it may need treatment at about 11-12 years of age.

______ I accept treatment

______ I decline treatment

Signature:____Date:______________________________

HIPAA PATIENT PRIVACY INFORMATION

Patient's Name: ______________________________ Patient's Date of Birth: ______________________

RELEASE OF MEDICAL/DENTAL INFORMATION

I give my permission to release confidential health information to the following people:

Name: ______________________________ Relationship: ______________________

Name: ______________________________ Relationship: ______________________

Name: ______________________________ Relationship: ______________________

***Please specify if there is any personal health information you DO NOT want to be disclosed to the above-named people: ______________________

____

____

TELEPHONE CONTACT

Please read the following choices and tell us whether or not we may leave messages regarding your medical/dental information and with whom we may leave it with.

Primary phone number (including area code): ______________________

May we call you at this number? ❍ Yes ❍ No

May we leave a message on your voicemail asking to return our call? ❍ Yes ❍ No

May we leave a message on your voicemail regarding your dental care? ❍ Yes ❍ No

May we leave a message to return our call with the person answering the phone ? ❍ Yes ❍ No

Secondary phone number (including area code): ______________________

May we call you at this number? ❍ Yes ❍ No

May we leave a message on your voicemail asking to return our call? ❍ Yes ❍ No

May we leave a message on your voicemail regarding your dental care? ❍ Yes ❍ No

May we leave a message to return our call with the person answering the phone ? ❍ Yes ❍ No

Alternate phone number (including area code): ______________________

May we call you at this number? ❍ Yes ❍ No

May we leave a message on your voicemail asking to return our call? ❍ Yes ❍ No

May we leave a message to return our call with the person answering the phone ? ❍ Yes ❍ No

Additional notes or comments: ____

____

Signature: ______________________________ Date: ______________________

Please notify this office in writing of your request to change or update any of the above information.

HIPAA PRIVACY COMPLIANCE

NOTICE OF PRIVACY PRACTICES

As our patient or patient's parent/guardian, a copy of the Newman Family Dentistry Privacy Practices policy will be available at any time from our reception desk or directly from our office. This information can be shared with you at any time upon request.

COMPLAINTS/COMMENTS

If you have any complaints concerning our privacy practices, you may contact Holly Walton at (317) 293-3000 (NewmanFamilyDentistry.com).

YOU WILL NOT BE RETALIATED AGAINST OR PENALIZED BY US FOR FILING A COMPLAINT.

SIGNATURE REQUIRED

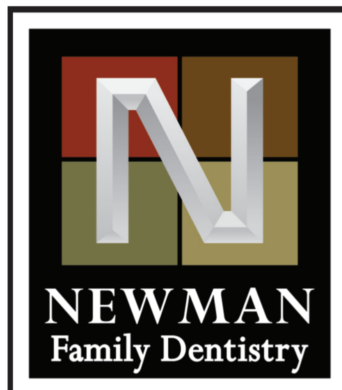
Your signature is required below indicating that the entirety of Newman Family Dentistry Privacy Practices Policy has been shared with you. By signing, you also acknowledge that an actual copy of this policy as been offered to you as well. This signature page will be maintained in your records and a copy will be provided to you upon request.

Parent/Guardian Signature: ______________________________

Parent/Guardian Name - Printed: ______________________________

Patient Name - Printed: ______________________________

Date: ______________________________



Revised 11-10-2014

FINANCIAL RESPONSIBILITY

FINANCIAL RESPONSIBILITY AGREEMENT

Our credit policies have been established to ensure that the best services can be provided to you and your family and any misunderstandings can be avoided.

Our professional services are rendered to the patient and not to the insurance company. The insurance company is responsible to the patient and the patient is responsible to the doctor. You are responsible for the payment of any and all bills not covered by or paid for by your insurance company.

For your convenience, our office has made arrangements with **Care Credit** to offer low monthly payments with fixed or no interest fee plans. Ask our front office staff for assistance in applying.

We believe our fees give an excellent value for the high quality and variety of services we provide. That said, please remember that what insurance companies call "Usual and Customary Fees" can vary widely with the dental plans offered by your employer and by which plan the employee selects.

PAYMENT IS DUE AND PAYABLE AS SERVICES ARE RENDERED

(Please indicate the manner in which you wish to handle payment on your account.)

_____________ 1. I will pay in full on the date of service/treatment by check, cash, credit card, debit card or Care Credit.

_____________ 2. I have insurance and I agree to pay my estimated portion the day of service/treatment by check, cash, credit card, debit card or Care Credit.

TREATMENT PLANS: All treatment plans given by Newman Family Dentistry are an ESTIMATE only. If you want a guaranteed price, we can submit a pre-determination to your insurance company.

INTEREST: We reserve the right to charge interest in the amount of 1.5% per month as provided by state law, or a billing fee of $12.50 on accounts 30 days or older.

CANCELLATION AND FAILED POLICY NOTICE: Due to an increase in demand for appointments, and to help better serve all our patients, we have implemented a "Cancellation and Failed Appointment Policy." Effective immediately, all cancellations require a 24 HOUR NOTICE. If we are not given proper notice, there will be a $35.00 charge added to your account. A failed appointment (a missed appointment without any notice) will result in a $50.00 charge added to your account.

In consideration of treatment required, I accept full financial responsibility. Insurance forms will be completed as a courtesy to the patient; however, your estimated payment not covered by insurance is expected on the date of services/treatment rendered unless prior arrangements are made. I further agree that if this account is turned over to an attorney or collection agency, I wil be responsible for all collection fees, attorney fees, and interest and court costs. I also agree to assign any and all insurance benefits to be paid directly to Don M. Newman, D.D.S., P.C. (Newman Family Dentistry).

I HAVE READ THIS FINANCIAL AGREEMENT. I UNDERSTAND AND AGREE TO THIS FINANCIAL AGREEMENT

Parent or Responsible Party Signature: ____________________________________ Date: ______________________

PATIENT REGISTRATION

PATIENT INFORMATION

First Name: ______________________ Middle Initial: ________ Last Name: ______________________

Preferred Name: ______________________ Email*: ______________________

Address: ____
Street City State Zip

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Date of Birth: __________ SSN#: __________ Driver's License # & State of Issue: ______________

SEX: ❍ Male ❍ Female MARITAL STATUS: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Widowed

EMPLOYMENT STATUS: ❍ Full-time ❍ Part-time ❍ Retired STUDENT STATUS: ❍ Full-time ❍ Part-time

***Check if you would like to receive correspondence from us via email. ❍**

How did you hear about our practice (friend, family, internet search, etc.)? ______________________

RESPONSIBLE PARTY (If someone other than the patient)

First Name: ______________________ Middle Initial: ________ Last Name: ______________________

Address: ____
Street City State Zip

Home Phone: ______________________ Cellular Phone: ______________________

Work Phone: ______________________ Ext: ________ Email: ______________________

Date of Birth: __________ SSN#: __________ Driver's License # & State of Issue: ______________

❍ Responsible Party is also a Policy Holder for Patient ❍ Primary Insurance Policy Holder ❍ Secondary Insurance Policy Holder

DENTAL INSURANCE INFORMATION

Name of Insured: ______________________

Relationship to Insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured SSN: ______________________

Insured Date of Birth: ______________________

Employer: ______________________

Employer Address: ______________________

____

Insurance Company: ______________________

Insurance Company Address: ______________________

____

MEDICAL INSURANCE INFORMATION

Name of Insured: ______________________

Relationship to Insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured SSN: ______________________

Insured Date of Birth: ______________________

Employer: ______________________

Employer Address: ______________________

____

Insurance Company: ______________________

Insurance Company Address: ______________________

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