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Infant Frenectomy Registration

Today's Date:_____

Patient's Name:_____**Birth date:**_____**Gender:**_____**Age:**_____

Parent's Names:_____ **Phone:**_____

Address:_____ **City:**_____ **State:**_____

Pediatrician:_____

Who may we thank for referring you to us?_____

Birth and Medical History

Birth Weight:_____ **Current Weight:**_____

Birth History: Hospital / Home Term in Week _____ Vaginal/C-section Forceps/Vacuum Y/N

Pitocin: Y/N other_____ Any birth complications?_____

Heart disease_____**Bleeding disorders**_____ **Allergies**_____**Other**_____

Additional information regarding your child's health that should be considered_____

_____

1. Infants are usually given vitamin K at birth to prevent bleeding in the first 8 weeks of life. Did your child receive the vitamin K shot or pill? Y/N

2. Was your infant premature? Y/N If yes, how many weeks?_____

3. Has your infant had any surgery? Y/N If yes, please explain?_____

4. Has your infant experienced any of the following? Please check and explain as needed.

- ☐ Prolonged nursing (>20 min. each side)
- ☐ Incomplete nursing (not satisfied)
- ☐ Baby falls off the breast and sleeps
- ☐ Lip or tongue feels weak
- ☐ Baby slides off the nipple
- ☐ Chronic burping or flatulence (gassy)
- ☐ Distended or bloated belly
- ☐ Signs of reflux such as chronic spitting up or vomiting
- ☐ Signs of discomfort/frustration such as arching of back or clenching of the hands
- ☐ Clicking noises while nursing
- ☐ Lip or tongue cycles through sucking and movement for a short time then stops and recycles

- ☐ Unable to maintain seal/flange lip
- ☐ Chomping motion
- ☐ Are there signs of gagging/choking
- ☐ Unable to hold pacifier
- ☐ Poor weight gain
- ☐ Have to supplement with bottle- Breast Milk Formula or Both

Other_____

How long is an average nursing session? _____ How frequently does baby nurse?_____

5. Is your baby taking any medications? Y/N Reflux_____Thrush_____ Name of medication:_____

6. Has your baby had a prior surgery to correct the lip or tongue tie? If yes, when, where, by whom?

_____

7. Are you able to breastfeed? Y/N **If no, how long since your stopped breastfeeding?** _____

Do you wish to try to breastfeed again? Y/N

8. Do you have any of the following signs or symptoms? Please check and elaborate as needed.

- ☐ Painful nursing
- ☐ Bruised, cracked, everted, flat, inverted, blistered, blanched, flattened, lipstick shape, bleeding or misshapen nipples after nursing (please circle)
- ☐ Breast swelling or Clogged ducts
- ☐ Mastitis
- ☐ Using a breast shield
- ☐ Thrush of the nipples
- ☐ Milk supply: strong letdown, adequate, losing supply, not certain (please circle)
- ☐ Altered your diet If yes, why?_____
- ☐ Other_____

Have you consulted with a Lactation Consultant? Y/N If yes, name of consultant? _____

Is this your first child? Y/N

If this is not your first child, did you breastfeed your other child/children? Y/N

How long did you breastfeed your other children? What are your breastfeeding goals? _____

_____

It is crucial for the success of this treatment to follow up with trained professionals (lactation consultants, feeding specialists, pediatricians, etc.). Improving your breastfeeding experience will require a team to help you and your baby maximize the benefits afforded by the baby's added mobility. To the best of my knowledge, I certify that the above information is complete and correct. I understand that it is my responsibility to inform this office of any changes in my baby's medical status or any other information provided in this form.

I am the parent or legal guardian of _____ and I have authorization and ability to consent to treatment for this child. I do herby request and authorize Gregory D. Eller, DMD to examine and perform treatment for the child named above.

Signature of Parent or Guardian:_____ Date_____

Please Print Name: _____

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Thank you for scheduling an appointment with us. A tongue or lip-tie is a relatively common condition in infants and children and can be diagnosed at any age. Dr. Eller will evaluate your infant for a possible tongue and/or lip-tie. If treatment is advised we will either complete the treatment at the same visit or at a later date. We invite you to bring a loved one, if you wish. However, we ask that you make arrangements for any other children. This will help you focus all of your attention on your baby. We provide a comfortable, private nursing room for you to wait while treatment is performed and to breastfeed your child following treatment.

All financials will be discussed prior to treatment. Our fees are: **Consultation- No Charge, Tongue Tie $450, Lip Tie $450. If tongue tie and lip tie are treated the same day total will be $525**. Payment is due prior to treatment being performed. We accept several forms of payment: Visa, MasterCard, Discover, American Express, Cash, Check and Care Credit.

We do not charge any additional follow-up visit fees (we will schedule a 1-2 week follow up after the procedure). If the procedure needs to be repeated for any reason within the first year there is no additional charge.
If you would like, we will provide you with a blank medical claim form and documentation so you can file it at your convenience to try to receive reimbursement from your medical plan. Please know that many plans do not cover the procedure (non-covered service), and there is no guarantee that filing a claim will result in reimbursement. All insurance questions and reimbursement questions should be handled between you and your insurance company. We are not in-network with any plans and do not file insurance on your behalf. Please let us know if you have any questions.

We send treatment letters to healthcare providers regarding your child's visit to our office that you list on this form. This helps promote a strong relationship between our office and other healthcare providers. If for any reason you do not want us to send a letter to your pediatrician, midwife, lactation, chiropractor, etc., please list names of providers to exclude. _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement. If so we will not be allowed provide any requested documentation to your medical insurance company if they request it. The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Alpine Family Dental (Gregory D. Eller, DMD PC). A copy of the signed, dated document shall be effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PROTECTED HEALTH INFORMATION (PHI) DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.

Print Patient Name:_____

Signature of Patient and/or Legal Guardian:_____Date:_____

Relationship to Patient: _____

Please list any other people who are allowed access to your PHI, this may include spouse, partner, step parents, parents, grandparents, care takers or any other individual.

Name:_____ **Relation:**_____

Name:_____ **Relation:**_____

OFFICE USE ONLY: As privacy officer, I attempted to obtain the patient's (or legal guardians) signature on this acknowledgement but was not able to because
It was an emergency treatment **I could not communicate with the patient** **The patient refused to sign** **The patient was unable to sign** **Other**
Signature of Privacy Officer: _____