New Generation Dental Center

Tongue Tie Registration Form (0-18 months)

Patient Information

Child's Name: _____ Date of Birth: _____

Sex: _____ Address: _____

Parent #1 Name: _____ Relation to Patient: _____

Cell: _____ Email: _____

Parent #2 Name: _____ Relation to Patient: _____

Cell: _____ Email: _____

Is it ok to text you for follow-up questions and appointment reminders? (Check one) □Yes □No

Whom may we thank for referring you? _____

Medical Insurance

Medical Insurance Provider: _____

Subscriber ID: _____ Group Number: _____

Subscriber's Name: _____Subscriber's Date of Birth: _____

Dental Insurance

Dental Insurance Provider: _____

Subscriber ID: _____ Group Number: _____

Subscriber's Name: _____Subscriber's Date of Birth: _____

Please bring your medical and dental insurance cards to your visit. We will not be able to submit to your insurance without a copy of your card. *Please note: Dr. Aaronson is an out-of-network provider for all medical and dental insurance and coverage is not guaranteed. It is recommended that you call your insurance company prior to your appointment to see what is covered.*

Medical History

Child's birth weight: _____ Current weight: _____

Delivery location: □Hospital □Home □Other Delivery type: □Vaginal □C-Section

Full term? □Yes □No If no, how many weeks gestation at birth? _____

Were there any additional stressors with labor/delivery? □Long labor □Excessive pushing □Breech birth

□ Forceps/vacuum use □Unplanned C-Section

Is your child currently under the care of a primary physician? □Yes □No

Physician's name: _____ Physician's phone: _____

Your child's current physical health: □Excellent □Good □Fair □Poor

Does your child have any allergies? □Yes □No If yes, explain: _____

Does your child have a history of heart disease? □Yes □No If yes, explain: _____

Has your child received their vitamin K drops or shot? □Yes □No □Unsure

Is there any family history of a bleeding/clotting disorder or keloid/excessive scarring? □Yes □No

Has your child been seen by a bodyworker (e.g. osteopath, chiropractor, physical therapist)? □Yes □No

If yes, please explain: _____

Breastfeeding Symptoms

If you are not breastfeeding/chestfeeding, please skip this section

Is this your first time breastfeeding? □Yes □No If no, explain: _____

Are you currently working with a lactation specialist (e.g. IBCLC?) □Yes □No

If yes, please provide the name of your IBCLC: _____

Please rate your level of discomfort while feeding (or when you did breastfeed): [circle one]

0 (None) 1 (Very Low) 2 (Low) 3 (Medium) 4 (High) 5 (Very High)

Are you noticing your nipples becoming creased/flattened/lipstick-shaped/blanched white? □ Yes □ No

Are your nipples becoming cracked, bruised, or blistered after nursing? □ Yes □ No

Are your nipples bleeding or scabbing? □ Yes □ No

Are you experiencing incomplete or poor breast drainage? □ Yes □ No

Do you have a history of, or currently have, mastitis or breast infection? □ Yes □ No

Do you have a history of, or currently have, nipple/infant thrush? □ Yes □ No

How is your milk supply? □ Oversupply □ Adequate □ Losing supply □ Poor

Do you use a nipple shield when nursing? □Yes □Sometimes □No

How many times a day do you breastfeed? _____ How many minutes per side? _____

Infant Symptoms

Does your infant fall asleep while attempting to nurse?	□Yes	□Sometimes	□No
Does your infant slide off the breast while latching/feeding?	□Yes	□Sometimes	□No
Does his/her upper lip curl inward (does not flip out) when latched?	□Yes	□Sometimes	□No
Does your infant have his/her mouth open at rest?	□Yes	□Sometimes	□No
Does milk or formula leak/spill out of the mouth while feeding?	□Yes	□Sometimes	□No
Does your infant become visibly frustrated at the breast?	□Yes	□Sometimes	□No
Does your infant exhibit reflux symptoms?	□Yes	□Sometimes	□No
Is your infant extremely gassy?	□Yes	□Sometimes	□No
Has your doctor noticed slow or poor weight gain?	□Yes	□No	
Does your infant chew on or “gum” the nipples while feeding?	□Yes	□Sometimes	□No
Is there a noticeable “clicking noise” while feeding?	□Yes	□Sometimes	□No
Does your infant seem satisfied/content after nursing sessions?	□Yes	□Sometimes	□No

Do you have any other feeding concerns? _____

_____

Authorizations

During office procedures, photographs or videos may be taken for educational purposes, such as lectures, professional articles, and presentations. These photos will never show your child's full face and your child's name will never be used. Do you consent for photos & videos to be taken of the procedure and used for educational purposes? □ Yes □ No

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize New Generation Dental Center to release any information to my child's insurance company and/or healthcare providers. **I understand that my insurance carrier may pay less than the actual bill for services**. I consent for my child's treatment status to be shared with their other medical providers, including, but not limited to, pediatricians, IBCLCs, and bodyworkers.

I agree to be responsible for payment of all services rendered on my child's behalf, and **I understand that payment is expected at the time of service**, unless other arrangements are made. The fee for each frenectomy site (i.e. tongue, lip/cheek) is $649. Lip and cheek ties are considered to be a single site, therefore the maximum charge would be $1,298.

I understand that I must provide at least 24 hours notice if I need to cancel or reschedule an appointment. I understand that failure to provide at least 24 hours notice will result in a $50 fee for every hour of the broken appointment.

HIPAA Authorization: I acknowledge that I have read and understand this office Notice of Privacy Practices, and I have had the opportunity to ask questions and receive my own copy of the notice, if I have requested one.

Parent/Guardian Signature: _____ Date: _____