

New Patient Registration

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender \_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1st Parent’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1st Parent’s Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2nd Parent’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2nd Parent’s Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pediatrician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical History:

Any medical conditions or concerns for your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any medications your child is taking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any allergies to foods or medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any previous surgeries or had frenum clipped previously? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other information we need to know?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below, I acknowledge that I have read and received the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

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 child’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 hereby request and authorize Tongue-Tie Dental PLLC to examine and perform treatment if necessary for the child named above.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Infant’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_Male \_\_\_\_\_\_\_Female Birth Weight \_\_\_\_\_\_\_\_\_\_\_\_ Present Weight \_\_\_\_\_\_\_\_\_\_\_\_ Birth Location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_Vaginal birth \_\_\_\_\_\_\_\_C-Section Birth Any birth complications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you presently breastfeeding \_\_\_\_\_Yes \_\_\_\_\_No If no, how long since you stopped breastfeeding \_\_\_\_\_\_\_\_\_\_\_\_\_

Medical History:

1. Infants are usually given vitamin Kat birth. Did your child receive the vitamin K shot? \_\_\_\_Yes \_\_\_\_No

2. Was your infant premature? \_\_\_\_ Yes \_\_\_\_ No If Yes, how many weeks? \_\_\_\_\_\_\_\_\_\_\_\_\_

3. Does your infant have any heart disease \_\_\_\_ Yes \_\_\_\_ No or known bleeding diseases? \_\_\_\_Yes \_\_\_\_ No

4. Has your infant had any surgery? \_\_\_\_ Yes \_\_\_\_\_ No

**5. Has your infant experienced any of the following? Please check / circle / elaborate as needed.**

\_\_\_\_ Shallow latch at breast or bottle

\_\_\_\_ Falls asleep in the middle of a feed

\_\_\_\_ Slides or pops on and off the nipple

\_\_\_\_ Gagging, choking, or coughing when eating

\_\_\_\_ Poor or slow weight gain

\_\_\_\_ Hiccups often \_\_\_\_ Lots of *in utero* hiccups

\_\_\_\_ Gumming or chewing the nipple

\_\_\_\_ Pacifier falls out easily or won’t stay in

\_\_\_\_ Snoring, noisy breathing, or mouth breathing

\_\_\_\_ Short sleeping and waking often

\_\_\_\_ Baby moves a lot in sleep/restless sleep

\_\_\_\_ Baby seems always hungry and not full

\_\_\_\_ Lip curls under when nursing or taking bottle

\_\_\_\_ Clicking or smacking noises when eating

\_\_\_\_ Sucking blisters or callouses on lips

\_\_\_\_ Colic symptoms / Baby cries a lot

\_\_\_\_ Reflux symptoms

\_\_\_\_ Spits up often? Amount / Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Gassy (toots a lot) / Fussy often

\_\_\_\_ Milk leaks out of mouth when nursing/bottle

\_\_\_\_ Nose sounds congested often

\_\_\_\_ Baby is frustrated at the breast or bottle

How long does baby take to eat? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often does baby eat? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Is your infant taking any medications? \_\_\_\_ Reflux \_\_\_\_\_Thrush Name of medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. Do you have any of the following signs or symptoms now or in the past? Please check/circle/elaborate.**

\_\_\_\_ Creased, flattened, or blanched nipples

\_\_\_\_ Lipstick shaped nipples

\_\_\_\_ Blistered or cut nipples

\_\_\_\_ Bleeding nipples

Pain on a scale of 1-10 when first latching \_\_\_\_\_\_\_\_

Pain (1-10) during nursing \_\_\_\_\_\_\_

\_\_\_\_ Poor or incomplete breast drainage

\_\_\_\_ Decreasing milk supply

\_\_\_\_ Plugged ducts / engorgement / mastitis

\_\_\_\_ Nipple thrush

\_\_\_\_ Using a nipple shield

\_\_\_\_ Baby prefers one side over other \_\_\_\_\_ (R/L)

\_\_\_\_ Feelings of hopelessness / depression

Primary Care Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chiropractor/PT/CST\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lactation Consultant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Therapist/Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who referred you to us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How far away do you live? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images**

**Authorization:** I authorize the use and disclosure of my name, photo- graphic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

**Purpose:** The photographic/video images, and/or testimonial will be used for: *Social Media and/or Advertising , or Teaching*

**Revocability:** I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

**No Treatment Conditions:** I understand that the practice cannot condition treatment on whether or not I sign this authorization.

**If desired, copy provided:**

**\_\_\_\_\_\_** “Yes, I would like a copy of this form”. (Initialed by team member, copy provided by \_\_\_\_\_\_\_\_\_\_\_\_\_)

**Patient name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If patient is a minor:

Parent/Legal Guardian name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Agreement For Reimbursement From Insurance for Tongue & Lip-Tie Procedure**

I understand that my insurance company reimbursed the Tongue-Tie Dental instead of mailing a check directly to me. Tongue-Tie Dental will reimburse me via credit card for the amount that was paid by the insurance company up to the amount paid by me, the parent, not including any discounts I may have received.

Occasionally, insurance companies will take back (recoup) the full or partial amount that has been paid to Tongue-Tie Dental (often months or even a year later) and I will be responsible for the balance once again. **I hereby authorize Tongue-Tie Dental to collect these funds by the credit card on file, or I will give another payment method within 2 business days if I receive a reimbursement check directly from the insurance company that was taken from the amount paid to Tongue-Tie Dental.** I understand this is simply to prevent double reimbursement from both Tongue-Tie Dental and my insurance company, in order to be fair to both Tongue-Tie Dental and myself.

Card number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp. Date \_\_\_/\_\_\_/\_\_\_\_\_

CVV Code: \_\_\_\_\_ Billing Zip Code: \_\_\_\_\_\_\_\_\_\_

Parent’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_