Shape

Description automatically generated with low confidence

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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthday \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_ Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medications taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous clip or release of tongue? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(date)

**1. Has your child experienced any of the following issues? Please check or elaborate as needed.**

**Speech**

\_\_\_ Frustration with communication

\_\_\_ Difficult to understand by parents

\_\_\_ Difficult to understand by outsiders

\_\_\_ % Percent of time you understand your child

\_\_\_ Difficulty speaking fast

\_\_\_Difficulty getting words out (groping for words)

\_\_\_ Trouble with sounds (which?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Speech delay (when?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Stuttering

\_\_\_ Speech harder to understand in long sentences

\_\_\_ Speech therapy (how long)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Mumbling or speaking softly

\_\_\_ “Baby Talks” or uses baby voice

**Feeding**

\_\_\_ Frustration when eating

\_\_\_ Difficulty transitioning to solid foods

\_\_\_ Slow eater (doesn’t finish meals)

\_\_\_ Small appetite / Trouble gaining weight

\_\_\_ Grazes on food throughout the day

\_\_\_ Packing food in cheeks like a chipmunk

\_\_\_ Picky eater/ with textures (which?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Choking or gagging on food

\_\_\_ Spits out food

\_\_\_Won’t try new foods

\_\_\_ Other:

**Nursing or Bottle-Feeding Issues as a Baby**

\_\_\_ Painful nursing or shallow latch

\_\_\_ Poor weight gain

\_\_\_ Reflux or spitting up

\_\_\_ Gassy (tooted a lot) as baby

\_\_\_ Milk leaked out of mouth / messy eater

\_\_\_ Poor milk supply

\_\_\_ Nipple shield needed for nursing

\_\_\_ Clicking or smacking noise when eating

\_\_\_ Cried a lot / colic as baby

\_\_\_ Other:

**Sleep Issues**

\_\_\_ Sleeps in strange positions

\_\_\_ Sleeps restlessly (moves a lot)

\_\_\_ Wakes easily or often

\_\_\_ Wets the bed

\_\_\_ Wakes up tired and not refreshed

\_\_\_ Grinds teeth while sleeping

\_\_\_ Sleeps with mouth open

\_\_\_ Snores while sleeping (how often) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Gasps for air or stops breathing (sleep apnea)

**Other Related Issues Lip-Tie Issues**

\_\_\_ Neck or shoulder pain or tension \_\_\_ Difficult or fights to brush top teeth

\_\_\_ TMJ Pain, clicking, or popping \_\_\_ Top teeth don’t show when smiling

\_\_\_ Headaches or migraines \_\_\_ Gap between two front teeth

\_\_\_ Strong gag reflex \_\_\_ Cavities on front teeth

\_\_\_ Prolonged thumb sucking / pacifier use. \_\_\_ Trouble eating from a spoon/ flips spoon over

\_\_\_ Mouth open /mouth breathing during the day \_\_\_ Trouble with B,P,M or W sounds

\_\_\_ Tonsils or adenoids removed previously

\_\_\_ Ear tubes previously / lots of ear infections **Any Other Issues or Concerns?**

\_\_\_ Reflux (medicated or not)

\_\_\_ Hyperactivity / Inattention

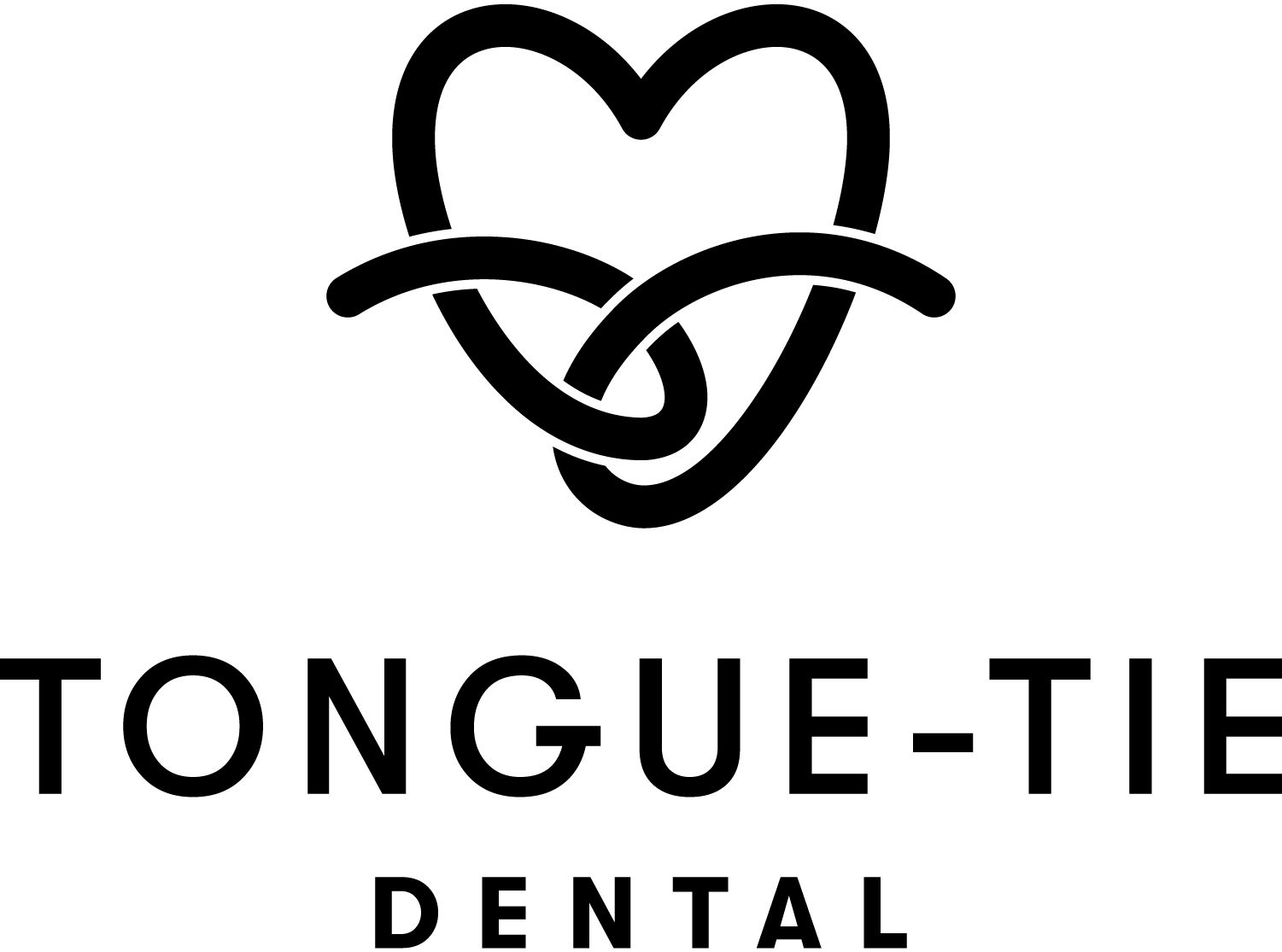
\_\_\_ Constipation

Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_