New Patient Registration

Child's Name: ____________________________________ Birthdate:____________________
Gender ____ Age: _____________ Preferred Name: __________________________________

Parent's Name: _________________________________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 Alabama Tongue-Tie Center to examine and perform treatment if necessary for the child named above.

Signature: _______________________________________ Date:______________________

Patient's Name ________________________________Birth date _________________ Today's Date ____________________

Medical problems: _______ Heart disease __________ Bleeding disorders ___________ Other___________________

_____Male ______Female Birth Weight __________ Present Weight __________ Birth Hospital_______________

______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 K at birth to prevent bleeding in the first 8 weeks of life. 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
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 while eating
___Slides or pops on and off the nipple
___ Colic symptoms / Cries a lot
___ Reflux symptoms
___ Clicking or smacking noises when eating
___ Spits up often? Amount / Frequency____________
___ Gagging, choking, coughing when eating
___ Gassy (toots a lot) / Fussy often
___ Poor weight gain
___ Hiccups often
___ Lip curls under when nursing or taking bottle

____Gumming or chewing your nipple when nursing
____Pacifier falls out easily, doesn't like, won't stay in
____ Milk dribbles out of mouth when nursing/bottle
____ Short sleeping requiring feedings every 1-2hrs
____Snoring, noisy breathing or mouth breathing
____Feels like a full time job just to feed baby
____ Nose 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, by whom?

____

7. Do you have any of the following signs or symptoms? Please check / circle / elaborate as needed.

___ 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
___ Infected nipples or breasts
____Plugged ducts / engorgement / mastitis
____Nipple thrush
____ Using a nipple shield
____Baby prefers one side over other ____ (R/L)

Pediatrician ____Phone number: ______________________________

Lactation Consultant _______________________________________Phone number:_______________________________

Who referred you to us? __________________________

Doctor's Signature ________________________________

ALABAMA TONGUE-TIE CENTER

Dear Valued Patients,

We are delighted that you chose the Alabama Tongue-Tie Center for your child's tongue-tie or lip-tie procedure. A tongue or lip-tie is a relatively common condition in infants and children and can be diagnosed at any age. Restricted oral tissues can affect breastfeeding, bottle-feeding, sleep, solid feeding, speech, and other important functions now and in the future. Dr. Baxter will evaluate your infant or child for any oral restrictions. When the type of treatment has been decided, we can either complete the treatment at the same visit or at a later date. All financial arrangements will be discussed with you before treatment begins. We aim to offer the highest level of customer service and clinical excellence. We do not charge for any follow-up visits, buccal cheek ties if needed, or if the procedure needs to be re-done for any reason in the first year, so this investment in your child's health is all-inclusive.

We will provide you with a health insurance claim form to mail to your insurance company on your own to try to receive reimbursement. As a dental office, we are unfortunately considered out-of-network for medical insurance companies. We do not file the procedure with dental insurance because it is excluded since a tongue or lip-tie is considered a "congenital anomaly." (Please note: Medicaid and ALLKids do not provide any out-of-network benefits, so we cannot provide a form for you to receive reimbursement.) Unfortunately, some health plans do not cover the procedure (non-covered service) or have a high deductible, so there is no guarantee that filing a claim will result in reimbursement.

Recommended Treatment For Your Child: (For ATTC Staff Use)

Exam / Tongue-Tie Release / Lip-Tie Release / Buccal Tie Release / Nitrous Oxide

Your responsibility : $ ______________

Please let us know if you have any questions.

Sincerely,

Dr. Baxter and Team

By signing below, you agree to be responsible for payment of services rendered at Alabama Tongue-Tie Center, and you understand that payment is due in full at the time of service for the procedure.

Child's Name:_____________________________________ Birthdate: __________________

Parent Name: ______________________________________ Today's Date: _______________

Parent Signature: ___________________________________