



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: \_\_\_\_\_

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 K at 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 \_\_\_\_\_





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: \_\_\_\_\_