ALABAMA TONGUE-TIE CENTER

New Patient Registration

Child's Name: _____ Birthdate:_____
Gender ____ Age: _____ Preferred Name: _____

Parent's Name: _____Parent's Birthdate: _____
Cell:_____ Alternate Phone Number: _____
Email:_____
Address:_____
Primary Care Provider:_____
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 _____Birthday _____Age____ Today's Date _____

Medical issues: _____ Medications taking: _____

Allergies: _____ Previous clip of tongue/lip? (when/where) _____

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
___Constipation
___Reflux (medicated or not)
___ Affects family dynamics (can't eat out, etc.)

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
___ Neck or shoulder pain or tension
___ TMJ Pain, clicking, or popping
___ Headaches or migraines
___ Strong gag reflex
___ Prolonged thumb sucking / pacifier use.
___ Mouth open /mouth breathing during the day
___ Tonsils or adenoids removed previously
___ Ear tubes previously / lots of ear infections
___ Hyperactivity / Inattention

Lip-Tie Issues
___ Difficult or fights to brush top teeth
___ Top teeth don't show when smiling
___ Gap between two front teeth
___ Cavities on front teeth
___ Trouble eating from a spoon/ flips spoon over
___ Trouble with B,P,M or W sounds

Any Other Issues or Concerns?

Primary Care Provider _____ Chiropractor/PT/CST_____

Speech/Feeding Therapist _____ Other Therapist/Provider_____

Who referred you to us? _____ How far away do you live? _____

Doctor's Signature _____

ALABAMA TONGUE-TIE CENTER

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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. We 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 also treating the lip-tie), 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, and no surprises.

We will provide you with a health insurance claim form to mail to your insurance company on your own for a possible reimbursement. As a dental office, we are unfortunately considered out-of-network with 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." 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.

Medicaid Patients: Medicaid does not provide any out-of-network benefits, so we cannot provide a form for you to receive reimbursement. There are Medicaid providers who perform the procedure under general anesthesia, and it would be covered, and you are choosing to go out-of-network and pay out of pocket for this procedure.

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

Exam / Tongue-Tie / Lip-Tie / Buccal-Ties / Frenuloplasty (Sutures) / Nitrous Oxide

Your responsibility : $ _____

Please let us know if you have any questions.

By signing below, you agree to be responsible for payment of services rendered at the Alabama Tongue-Tie Center, and you understand that payment is due in full at the time of service for the procedure. You also agree that you were informed of our fees before the visit and before treatment took place.

Child's Name:_____ Birthdate: _____

Parent Name: _____ Today's Date: _____

Parent Signature: _____