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:_____

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 breastfeeding or pumping? ____Yes ____No If no, how long since you stopped breastfeeding? _____

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. Any other medical conditions? _____
4. Has your infant had any surgery? ____ Yes _____ No What type? _____
**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
____ Constipation or irregular stools
How long does baby take to eat? _____
How often does baby eat? _____
Anything else?

6. Is your infant taking any medications? ____ Reflux _____Thrush Name of medication: _____

7. Any prior surgery to correct the tongue- or lip-tie? (when/where) _____

8. How are you doing mentally/emotionally? _____

**9. 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
Pain on a scale of 0-10 when first latching _____
Pain (0-10) during nursing _____
____ Feelings of hopelessness/depression

____ 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)

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 _____

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: _____