# FRENECTOMY PATIENT REGISTRATION AND HISTORY

## Patient Information

**Please Present ID & Insurance Cards at the Front Desk. Thank You!**

Today's Date_____

Patient Name_____
Last First Middle Initial

Birth date_____ Age_____ Sex ☐ M ☐ F

Address_____

City_____ State_____ Zip_____

E-mail_____

Home Phone_____

Cell Phone_____

Emergency contact_____Phone_____

Have we seen a member of your family before? Yes or No

Parent/Guardian Names_____

Parent/Guardian Employer_____

Occupation_____

Employer Phone_____

Reason for today's visit_____

_____

Whom may we thank for referring you?_____

## Minor/Child Consent

I, being the parent or guardian of

_____

Name of Minor/Child

do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
Date Signature of Insured/Guardian

## Insurance Information

Who is responsible for this account?_____

Relationship to Patient_____

**Is this medical or dental insurance? Circle one.**

**Primary Insurance Co.**_____

Subscriber's Name_____

Birthdate_____ SSN_____

ID#_____ Group#_____

Is patient covered by additional insurance? ☐ Yes ☐ No

**Secondary Insurance Co.**_____

Subscriber's Name_____

Birthdate_____ SSN_____

ID#_____ Group#_____

## Important Information Regarding Insurance Billing

All frenectomy patients pay for services up front unless the patient has verifiable Delta Dental PPO or Risk Management insurance.

### Medical Insurance:

We are not contracted with any medical insurances. We will send a medical claim as a courtesy to you. Assignment of benefits will be to you. We do not follow up with medical insurance companies to make sure the claim has been received by them or paid. Any follow up with medical insurance companies or disputes will be your responsibility. Any questions regarding whether the claim was received, should be directed to your insurance company. If they did not receive a claim, let us know and we will be happy to resend it!

### Dental Insurance:

We are only contracted with Delta Dental PPO & Risk Management. We will send a dental claim as a courtesy to you. If you have questions whether your insurance received the claim, please call the insurance company first. If they did not receive it, let us know so we can resend it. Assignment of benefits will be to us and we will contact you if there is a refund.

Please sign acknowledging that any and all insurance billing questions have been asked and answered & you understand our insurance policy!

_____
Signature of Insured/Guardian

# PATIENT REGISTRATION AND HISTORY CONTINUED

## HEALTH HISTORY

Lactation Consultant's Name_____Has patient had prior surgery to correct tongue/lip tie?_____

List any medications_____

Was a Vitamin K shot given at birth (to the baby)? ☐ yes ☐ no ☐ I don't know

Allergies: ☐ None Known ☐ Local Anesthetic ☐ Latex ☐ Shellfish ☐ Penicillin ☐ Other _____

Is there anything else we should know about your medical history?_____

Baby/Toddler's Symptoms: ☐ Poor latch ☐ Slides off the nipple when attempting to latch ☐ Colic Symptoms ☐ Reflux Symptoms ☐ Poor weight gain ☐ Gumming/chewing on nipple when nursing ☐ Unable to hold pacifier in mouth ☐ Wanting to nurse every 2-3hours ☐ Swallowing issues ☐ Breathing issues ☐ Food aversions

The information on this form is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I give permission to take before and after pictures of the surgery site. These pictures are used for documentation of the surgery and kept with your chart. If your insurance company request before and after pictures, we will send them.

_____ _____

Date Signature

## FRENECTOMY CONSENT

**The purpose of this procedure at a young age is to allow the baby to latch properly during breastfeeding and reduce maternal discomfort. For older children/adults the purpose is to gain and maintain good oral health, allow for more normal growth, allow for correct speech development, and to reduce any future problems associated with tongue and/or lip-ties.**

**During treatment, it may be necessary for your child to be restrained by you and the office staff to control undesirable movements. Dr. Jesse will use a small amount of topical anesthetic and local anesthetic to numb the area so your child will be comfortable during the procedure. The procedure is generally quick and there is very minimal bleeding. The laser cauterizes as it trims away the muscle fibers causing little bleeding and resulting in a scar free wound that will heal in one to two weeks.**

**Dr. Jesse anticipates great results; however, there are no guarantees as to how much benefit will be achieved after the procedure. Laser treatment usually proceeds as planned; however, as in all areas of medicine, results cannot be guaranteed, nor can all consequences be anticipated. Post surgical discomfort may be minimal or last as long as a week. Some parents say that their child was fussy the first night but had no complications. You may choose to give your child children's pain medication, but it is usually not necessary for most patients. After completing this type of surgery on thousands of infants, this office has not experienced any significant problems that would indicate any serious risks of the surgery.**

**Not treating your child's existing dental problem may result in continued breastfeeding problems, complications with bone growth and tooth eruption, tooth decay, and complications with future orthodontic treatment. Parents and guardians should understand recommended procedures, alternative options and anticipated results.**

**All surgery in this office is completed using appropriate laser technology, which has proven safe for infants as well as all patients. Successful results of this surgery depend on parents following all post-operative recommendations for keeping the surgical sites from healing together.**

**ACKNOWLEDGMENT OF INFORMED CONSENT**

**I herby acknowledge that I have been fully informed as to the treatment considerations. I have read and understand this form. I understand the advantages and disadvantages of treatment as well as alternative means of completing these procedures. I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I have been given the opportunity to ask Dr. Jesse and his staff all questions I have about the proposed surgical treatment. All questions and concerns have been discussed. I give my free and voluntary, informed consent for treatment to be completed. By signing this consent, I indicate that I have the legal authority to grant this permission. I certify that I read and write English and have read and fully understand this consent. I also agree to pay all fees and have given Dr. Jesse a complete medical history of my child.**

_____ _____ _____ _____

Date Signature of Parent/Guardian Print Name Relationship to Patient