FRENECTOMY PATIENT REGISTRATION

Today's Date ____________________ Chart # ____________

CHILD'S INFORMATION

Last Name ____________________ First Name ________________ DOB ________ Home # ______________

Sex: Male / Female ______ Home Birth ______ Hospital Birth ______ Vaginal Birth ______ C-Section

______ Bleeding Disorders ______ Other ______________________________

Birth Weight ______________ Present Weight ____________

Mother's Full Name ______________________________ SS# __________________ DOB ____________

Home Address ______________________________ City __________________ Zip ____________

Cell # __________________ Work # ______________ Email Address: ______________________

Father's Full Name ______________________________ SS# __________________ DOB ____________

Home Address ______________________________ City __________________ Zip ____________

Cell # __________________ Work # ______________ Email Address: ______________________

Marital Status: Married / Single / Separated / Divorced / Widowed

Who does the child live with? Both Parents / Mother / Father / Other ______________________________

Are you presently breastfeeding? Yes / No If no, how long since you stopped breastfeeding __________

Are you presently using a nipple shield? Yes / No Are you choosing not to breastfeed? Yes / No

Do you or any immediate family members have any bleeding disorders? Yes / No

Infants are usually given vitamin K at birth to prevent bleeding in the first 8 weeks of life. Did you sign any waiver to refuse the administration of vitamin K? Yes / No Has your infant had any surgery? Yes / No

Was your infant premature? Yes / No Does your infant have any heart disease? Yes / No

Is your child taking any medications? Yes / No If yes, please list: ______________________________

Mother's Symptoms

______ Painful latching of infant onto the breast
______ Gumming or chewing on the nipples
______ Bleeding, cracked or cut nipples
______ Infant unable to achieve a successful, tight latch
______ Poor or incomplete breast drainage
______ Infected nipples or breasts
______ Abraded nipples
______ Plugged ducts
______ Mastitis
______ Nipple thrush
______ Feelings of depression
______ Over/under supply of breast milk

Infant's Symptoms

______ Difficulty in achieving a good latch
______ Falls to sleep while attempting to nurse
______ Slides off the breast when attempting to latch
______ Aerophagia (clicking, swallowing air)
______ Poor weight gain
______ Short sleep episodes (feeding every 1-2 hours)
______ Apnea (snoring, heavy noisy mouth breathing)
______ Unable to keep a pacifier in the infant's mouth
______ Waking up congested in the morning
______ Only sleeping when held upright/in car seat
______ Gagging when attempting to introduce solids
______ Milk leaking out sides of mouth during feedings
______ Extremely long feedings
______ Top lip folds under when nursing

Pediatrician ______________________________ Phone Number ______________________

Address ______________________ City ______________ State ______ Zip ____________

Physician's Email Address ____

Has your physician evaluated your infant's lip and tongue ties? Y / N

Lactation Consultant ______________________________ Phone Number ______________________

Address ______________________ City ______________ State ______ Zip ____________

Referred to our office by ____

Did you use the internet to find my office Y / N Have you visited my website Y / N

Additional comments: ____

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Fellow – American Academy of Pediatric Dentistry

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Informed Consent for infant laser treatment

Prior to completing any oral care on your infant, we require your consent for treating your child. It is the philosophy of my office to provide children the highest quality of care in a manner which is as pleasant and safe as possible. During treatment on small infants, it may be necessary for your infant to be swaddled or place in a similar protective appliance to control undesirable movements. In some instances, there may be the need for Dr. Sherman to use a small amount of a topical anesthetic and to provide adequate visibility and access to the surgical areas using a comfortable mouth prop. The purpose of all these procedures are to gain and maintain good oral health, primarily at this age, breastfeeding, reducing maternal discomfort and in many instances future problems that may be associated with lingual and or lip-ties. Dr. Sherman anticipates good results. However, no guarantees as to the results are given. Laser treatment usually proceeds as planned; however, as in all areas of medicine, results cannot be guaranteed, nor can all consequences be anticipated. Post-treatment discomfort is usually minimal. Bleeding is always a rare possibility; however, after completing this type of treatment on 2,000 infants, this office has not experienced any significant problems that would indicate any serious risks of the treatment. Not treating existing dental problems in children may result in continuing breastfeeding problems. Successful breastfeeding is our primary goal for this procedure. Parents and guardians should understand recommended procedures, alternative options and anticipated results. All treatment in this office is completed using appropriate laser technology, which has proven safe for infants as well as all patients. Successful results of this treatment are dependent on parents carefully following **ALL POST OPERATIVE RECOMMENDATIONS FOR KEEPING THE SURGICAL SITES FROM HEALING TOGETHER, SEEING THEIR LACTATION CONSULTANT AND/OR PEDIATRICIAN, AS NEEDED, AND RETURNING FOR THE POST-OP EXAM IN OUR OFFICE.**

ACKNOWLEDGMENT OF INFORMED CONSENT

I hereby 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 my infant will be treated while I remain in the reception area. My office has explained to you, the purpose of the laser treatment through a consultation, oral discussions and written information. I have been given the opportunity to ask Dr. Sherman all questions I have about the proposed laser 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 also agree to pay all fees and have given Dr. Sherman a complete medical history of my child.

Child's Name: ______________________ Parent's Signature: ____________________________

Today's Date: ______________________

During office procedures photographs or videos on interesting cases may be completed. We would like your consent to use these for educational purposes such as lectures or professional articles to advance breastfeeding. Consent to use photos and videos: Parent Signature ___________________________

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Patient's Name ______________________ Date ____________________

INSURANCE VERIFICATION

New Jersey law requires us to disclose full insurance information on all claims submitted; therefore, our office requires the following information:

Primary: Insured's Name ______________________ Birth Date ______________

Address ______________________ SS # ______________

Employer Name ______________________

Employer Address ______________________

Insurance Company – Name ______________________

Address ______________________

Tel No. ______________________

ID # ______________ Group/Plan # ______________

Secondary: Insured's Name ______________________ Birth Date ______________

Address ______________________ SS # ______________

Employer Name ______________________

Employer Address ______________________

Insurance Company – Name ______________________

Address ______________________

Tel No. ______________________

ID # ______________ Group/Plan # ______________

If any dependent child is over the age of eighteen, please supply the following:

Name of child ______________________

Name of F/T school attending ______________________

Please be advised that our office only processes your primary insurance claims.
Once your primary insurance has paid us, you assume full financial responsibility for any balance remaining.
It is also your responsibility to process any claims needed for your secondary insurance.
The above secondary insurance information is for disclosure purposes only.
Thank you for your cooperation.

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NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

Notice of Privacy Practices can be found on our website

I, ________________________, have read and understand this office's Notice of
(print full name)

Privacy Practices.

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

____

____

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FINANCIAL POLICY

Payment is due in full at the time dental treatment is provided. We accept cash, personal check, debit and credit card payments. We can also assist you in obtaining third party financing through CareCredit, which offers convenient monthly payment options, no up-front costs, no prepayment penalties and no annual fees.

Insurance
Our office is committed to helping you maximize your insurance policy and will gladly accept assignment of benefits. Because insurance policies vary greatly, we can only estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contracts. As our fees may exceed that which your insurance company covers for various services, your estimated patient portion must be paid at the time of service. Should your payment exceed the estimated patient portion, you will promptly be refunded the difference. Our office is not a contracted or "in-network" provider for **all** insurance companies, and as such, any fees not covered by your insurance company are solely your responsibility. As a service to our patients, we will bill insurance companies for services.

In an effort to reduce the amount of billing errors, paper statements, and past-due collections accounts, we require that you keep a debit or credit card authorization on file with our office. This authorized method of payment will be used to clear any potential balances that may occur after we receive payment from your insurance company. In the event that it becomes necessary to use this authorized method of payment, you will receive a courtesy phone call to the primary phone number provided before any charges are assessed. If no response is received after 48 hours, the charges will automatically be assessed and you will receive a receipt and a copy of your patient account statement via mail.

If your account balance is 120+ past due, it will be turned over to a collections agency. Please contact our office to discuss additional payment options should the need arise.

I have read, understood, and had all questions answered about the financial policies in effect at Shore Children's Dental Care.

Print Name: ______________________________

Signed: ______________________________ Date: ____________________

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Credit Card Authorization

I authorize Shore Children's Dental Care to keep my signature of file and to charge the following credit card should a balance remain on my account.

- I understand that the estimated patient portion of my office visit will be collected at the time of service.
- Once insurance has been processed, if a balance remains on my account, I will receive a statement in the mail that I must pay within 30 days. If this amount is not paid within that time, I understand that I will receive a courtesy call that the amount will go on my card.
- If this authorization applies to a payment plan option previously agreed upon with a staff member of SCDC, I understand that my card will be charged $ ___________ on the ______ day of every month until my balance is paid in full. Initials ____________
- In the event of an overpayment on the following credit card, I will receive a courtesy call and be given options for reimbursement.

Patient Name(s): ____

Phone (H): __________________ (W): __________________ (C): __________________

Card Type: VISA _______ MASTERCARD _______ DISCOVER _____ AMEX ________

Card # _______________________________________ CVV Code ______ Exp Date ____________

Name As It Appears On Card: ____

Cardholder Signature: ____________________________________ Date: _____________________

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