

Infant Frenectomy Health History and Intake

Patient Name: _____ Date of Examination: ____/____/____

Birth Date: ____/____/____ Age: _____ Gender: M F

Parent name(s) _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: home _____ work _____ cell _____

Email: _____

Referred by: _____ Reason: _____

Medical History

Baby's Physician: _____ Phone number: _____

Birth weight: _____ Current weight: _____ Gestational age at birth: _____ weeks

Baby's current medications (including over the counter, vitamins, herbs, homeopathic, prescription):

If breastfeeding: Breastfeeding parent's current medications (over the counter, vitamins, herbs, prescription):

Has anyone in your family had life threatening reactions to any type of anesthesia? Yes No

If yes, explain _____

Has your baby had the following:

*Vitamin K injection at birth	Yes	No	
Complications during birth	Yes	No	If yes, explain _____
Jaundice	Yes	No	If yes, explain _____
Cyanosis (turning blue)	Yes	No	If yes, explain _____
Breathing problems or asthma	Yes	No	If yes, explain _____
Swallowing issues/gagging	Yes	No	If yes, explain _____
Bleeding problems	Yes	No	If yes, explain _____
Heart problems	Yes	No	If yes, explain _____
Anemia	Yes	No	If yes, explain _____
HIV	Yes	No	If yes, explain _____
Other infections	Yes	No	If yes, explain _____
Kidney disease	Yes	No	If yes, explain _____
Surgery or hospitalization (including NICU)	Yes	No	If yes, explain _____
Congenital defects	Yes	No	If yes, explain _____
Allergies (including to food, medications)	Yes	No	If yes, explain _____
Has your baby had a frenectomy before?	Yes	No	If yes, date(s) and provider name _____

Please list ANY other health or medical concerns not listed: _____

Baby's symptoms

- Poor or shallow latch
- Slips off the nipple or chews on the nipple
- Falls asleep while attempting to feed
- Colic symptoms
- Reflux symptoms
- Poor weight gain or "failure to thrive"
- Short sleep episodes
- Breast or bottle refusal
- Fussiness at the breast or bottle
- Clicking sound while feeding
- Leaking milk from the sides of the mouth
- Gagging
- Noisy breathing/snoring
- Painful gas
- Lip blisters
- Thrush
- Other: _____

Breastfeeding parent's history and symptoms

- Not currently breastfeeding
- Over supply
- Under supply
- Engorgement
- Plugged ducts or Mastitis
- Creased or blanched nipples after nursing
- Bleeding or cracked nipples or other nipple damage
- Thrush or other infections
- Pain while nursing
- Flat, inverted or "shy" nipples
- Insufficient glandular tissue (IGT)
- Polycystic ovary syndrome (PCOS)
- Retained placenta
- IV fluids during labor and/or birth
- Depression (including postpartum depression)
- Other: _____

Feeding History

Are you currently working with a lactation consultant, speech pathologist or feeding specialist? Yes No
 If yes, name _____ Date last visit _____

If baby is breastfeeding, is this your first baby to nurse? Yes No
 If no, how long were other children nursed? _____

How many times in 24 hours does baby nurse/feed? _____ How long per session? _____

Frequency of poopy diapers per day: _____ Frequency of wet diapers per day: _____

Does baby sleep through the night? Yes No

Do you use a nipple shield to nurse? Yes No

Does baby take a bottle? Yes No

Does baby take a pacifier? Yes No

Do you use a breast pump? Yes No
 If yes, for what reason? (working, engorgement, etc.) _____

Does baby receive any formula? Yes No
 If yes, how much and how often? _____

Has baby been treated by a chiropractor, craniosacral therapist, physical therapist or other body worker? Yes No
 If yes, by whom and when? _____

Has anyone in your family had a tongue or lip tie? Yes No
 If yes, who? Was it treated? _____

What are your breastfeeding goals? _____

Is there any other information you feel may be important for the care of your baby? _____

I (name of parent/guardian): _____ understand that the information that I have given is correct to the best of my knowledge and it is my responsibility to inform the office of any changes in my child's medical status.

Signature: _____ Date: _____

Confirmation Policy

Effective immediately: In order to guarantee your reservation with our office you MUST confirm with us no later than 7:00 am on the day before your appointment. If you fail to contact our office to make the necessary confirmation we will not be able to guarantee your reservation and your time may be used for the treatment of other patients.

Your appointment time is your responsibility to remember. As a courtesy, we will attempt to contact you (2) business days prior to your appointment to confirm. If we are unable to reach you we will leave a message reminding you to call us to confirm.

We pay the entire staff to be here for your reserved appointment time. If you do not confirm your reservation we will have no other choice but to offer it to another patient in order to cover our expenses.

We still require two (2) business days' notice to cancel or change your appointment time. Failure to provide sufficient notice may result in not accepting advance reservations for your family and you will be placed on a same day only basis.

I have read and understand the cancellation policy.

Signature of Patient, Parent or Guardian

Date

Community Dental Care of Claremont Policy Agreement

Dental Services Available –

- ❖ Community Dental Care of Claremont provides basic preventive, restorative, surgical, prosthetic and educational dental services for children and adults of Sullivan County

Appointments –

In order to give every dental patient the attention they need we ask that you:

- ❖ Be on time for your appointment
- ❖ If you can not keep your appointment be sure to give us 2 business days notice – 603-287-1300

Community Dental Care of Claremont will not be able to continue to schedule appointment for patients who repeatedly break their appointments. An appointment is considered to have been broken if any of the following occur:

1. The patient fails to show up for an appointment
2. The patient arrives more than 10 minutes late for a scheduled appointment
3. The patient calls to cancel an appointment with less than 2 business days notice

When a patient has repeated broken appointments, the patient will not be allowed to schedule any further routine appointments. The patient may call daily for a possible same day appointment as the schedule allows or emergency services only. Additional broken appointments could lead to permanent dismissal from the dental practice.

Payment – Community Dental Care of Claremont offers payment options to help make dental care affordable to our patients. We will work with each patient to determine their financial responsibility and provide them with an estimate for dental services. ***Dental services must be paid for upon arrival on the day of treatment unless other financial arrangements have been made ahead of time.*** Please be sure to discuss any concerns you may have regarding your payment and payment options with the Dental Receptionist ***before*** the day of treatment.

Address and Telephone Number Changes – It is your responsibility to notify Community Dental Care of Claremont with any address and/or telephone number changes. If we are unable to contact you by mail or telephone to confirm your appointment, your appointment may be cancelled.

The staff of Community Dental Care of Claremont will make every effort to treat you with respect and courtesy and they expect that you will show them the same respect and courtesy in return.

Community Dental Care of Claremont reserves the right to terminate the patient relationship.

I have read, understand and agree to abide by these policies.

Patient or Legal Guardian if patient is under 18 years old

Date

Community Dental Care of Claremont
1 Tremont Street
Claremont, NH 03743

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES AND DENTAL RESTORATIVE MATERIALS

You May Refuse to Sign This Acknowledgement

I, _____ (patient name) have reviewed a copy of this office's **Notice of Privacy Practices and Dental Restorative Materials.**

Patient Name (Please print)

Signature of Patient (or Parent/Legal Guardian if Patient is a Minor)

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and Dental Restorative Materials, but acknowledgement could not be obtained because:

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

Community Dental Care of Claremont

Responsible Party Information

*If the patient is under the age of 18 or has a guardian, please fill out the following information regarding the **responsible party**:

Patient Name(s): _____

Responsible Party:

Name: _____
(Last) (First) (MI)

Address: _____

Responsible Party:

Date of Birth _____ **Social Security #** _____

Relationship Status: Married, Single, Partnered, Divorced or Other _____

Phone: _____
(Home) (Work) (Mobile)

Relationship to patient: _____

Signature _____ **Date** _____

HOUSING & PUBLIC FACILITIES

Sullivan County FAMILY INCOME VERIFICATION FORM – 2017

SURVEY #: _____ DATE: _____
 MUNICIPALITY: _____ PROJECT: _____
 SURVEY ADMINISTRATOR: _____

The following information is required to potentially apply for grant/loan funds for the Community Development Block Grant (CDBG) program. If you have any questions, please contact the survey administrator above. Your assistance in the completion of this form is greatly appreciated. It will be held in strict confidence, and used only to verify that we are meeting the requirements of the grant program.

Please complete both portions of the form – Part I and Part II

PART I INCOME AND HOUSEHOLD DATA

Please choose the row that represents your family size and circle the Income Category that best describes your family income. Family income includes wages and salaries, interest, net business income, social security, pensions, alimony received, VA benefits, and educational benefits received by all family members living at home. Alimony paid may be deducted. This verification form should reflect your current family income. This data is required by the CDBG program.

Family Size	Income Category A	Income Category B	Income Category C	Income Category D
1	\$0 to \$14,800	\$14,801 to \$24,650	\$24,651 to \$39,450	\$39,451 +
2	\$0 to \$16,900	\$16,901 to \$28,200	\$28,201 to \$45,050	\$45,051 +
3	\$0 to \$19,000	\$19,001 to \$31,700	\$31,701 to \$50,700	\$50,701 +
4	\$0 to \$21,100	\$20,101 to \$35,200	\$35,201 to \$56,300	\$56,301 +
5	\$0 to \$22,800	\$22,801 to \$38,050	\$38,051 to \$60,850	\$60,851 +
6	\$0 to \$24,500	\$24,501 to \$40,850	\$40,851 to \$65,350	\$66,351 +
7	\$0 to \$26,200	\$26,201 to \$43,650	\$43,651 to \$69,850	\$69,851 +
8	\$0 to \$27,900	\$27,901 to \$46,500	\$46,501 to \$74,350	\$74,351 +

PART II RACE, ETHNICITY AND HOUSEHOLD DATA

Data with regard to (1) Household Status; (2) Racial Characteristics and (3) Ethnicity information – in expanded categories – is being requested, in order to measure the impact of the program on the diverse population of the U.S.

Please circle the appropriate racial, ethnic, familial status, age, and handicapped category that applies to you. A number of categories may apply to you. Please note this information will be used for analysis purposes only. We ask you to provide this information on a voluntary basis. If you do not wish to provide the information, you may refuse to do so.

CIRCLE ALL IN EACH CATEGORY THAT APPLY

RACE

- White
- Black or African American
- Asian
- American Indian or Alaska Native
- Native Hawaiian or Other Pacific Islander
- American Indian or Alaska Native & White
- Black or African American & White
- American Indian or Alaska Native & Black or African American

ETHNICITY

- Hispanic or Latino
 - Not Hispanic or Latino
- HOUSEHOLD**
- Elderly (62 + years)
 - Handicapped
 - Female Head of Household
 - Not Applicable