Infant Frenectomy Health History and Intake

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

Birth Date:____/____/____ Age:_____ Sex: 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 breast/chestfeeding: 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 and/or reflux symptoms
- ☐ Poor weight gain or "failure to thrive"
- ☐ Short sleep episodes
- ☐ Fussiness or refusal of 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
- ☐ Difficulty with solids
- ☐ Speech Concerns
- ☐ Other:_____

Parent's history and symptoms (if breastfeeding)

- ☐ 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 breast/chestfeeding, 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 treatment 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:_____

AUTHORIZATION AND CONSENT FOR TREATMENT:
Please Read Carefully!

- I hereby authorize Community Dental Care of Claremont's dental providers to provide routine diagnostic, preventive and restorative dental services for me or my dependent named above. I understand that I will be given the opportunity to ask any questions I may have regarding this treatment. I understand that a perfect result cannot be guaranteed. I acknowledge that during treatment it may be necessary to change or add procedures because of conditions found while working on the tooth/teeth that were not detected during examination and that I will be informed of these changes, whenever feasible.
- I certify that the above information is accurate. I understand that providing false information can be dangerous to my health.
- I authorize Community Dental Care of Claremont to release information including diagnosis and treatment for me or my dependent to third party payors. I authorize and request my dental insurance company to pay all insurance benefits otherwise payable to me directly to Community Dental Care of Claremont.
- I understand that income and demographic information may be shared with State, Federal and private grants. I have been provided a copy of Notice of Privacy Practices. I acknowledge receipt and understanding of these documents.
- I agree to be responsible for payment of all services rendered to me or my dependent. I understand that there may be fees associated with my dental care that are my responsibility and due at the time services are rendered.

By signing, I am agreeing to all of the authorization and consent listed above.

_____ Date: _____

Patient/Parent/Legal Guardian

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:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o 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** _____