

# PATIENT REGISTRATION

## PATIENT INFORMATION

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ SEX:  Male  Female

Date of Birth: \_\_\_\_\_ SSN#: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

## RESPONSIBLE PARTY (If someone other than the patient)

Relationship to Patient: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN#: \_\_\_\_\_

*Please disregard next questions if same as above:*

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

Name of Policyholder: \_\_\_\_\_

Relationship to Policyholder:  Self  Spouse  Child  Other

Policyholder's SSN: \_\_\_\_\_

Policyholder's Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Member ID Number: \_\_\_\_\_

Plan/Group Number: \_\_\_\_\_

## SECONDARY DENTAL INSURANCE

Name of Policyholder: \_\_\_\_\_

Relationship to Policyholder:  Self  Spouse  Child  Other

Policyholder's SSN: \_\_\_\_\_

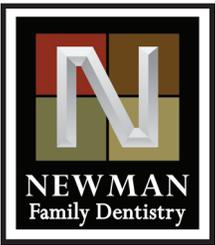
Policyholder's Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Member ID Number: \_\_\_\_\_

Plan/Group Number: \_\_\_\_\_



# HIPAA PATIENT PRIVACY INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## RELEASE OF MEDICAL/DENTAL INFORMATION

I give my permission to release confidential health information to the following people:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

\*\*\*Please specify if there is any personal health information you DO NOT want to be disclosed to the above named people: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## TELEPHONE CONTACT

Please read the following choices and tell us whether or not we may leave messages regarding your medical/dental information and with whom we may leave it with.

Primary phone number (including area code): \_\_\_\_\_

May we call you at this number?  Yes  No

May we leave a message on your voicemail asking to return our call?  Yes  No

May we leave a message on your voicemail regarding your dental care?  Yes  No

May we leave a message to return our call with the person answering the phone?  Yes  No

Secondary phone number (including area code): \_\_\_\_\_

May we call you at this number?  Yes  No

May we leave a message on your voicemail asking to return our call?  Yes  No

May we leave a message on your voicemail regarding your dental care?  Yes  No

May we leave a message to return our call with the person answering the phone?  Yes  No

Alternate phone number (including area code): \_\_\_\_\_

May we call you at this number?  Yes  No

May we leave a message on your voicemail asking to return our call?  Yes  No

May we leave a message to return our call with the person answering the phone?  Yes  No

Additional notes or comments: \_\_\_\_\_

\_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*Please notify this office in writing of your request to change or update any of the above information.\*\*\*



# HIPAA PRIVACY COMPLIANCE

## NOTICE OF PRIVACY PRACTICES

As our patient, a copy of the Newman Family Dentistry Privacy Practices policy will be available at any time from our reception desk or directly from our practice office. This information can be shared with you at any time upon request.

## COMPLAINTS/COMMENTS

If you have any complaints concerning our privacy practices, you may contact Holly Walton at (317) 293-3000 (NewmanFamilyDentistry.com).

YOU WILL NOT BE RETALIATED AGAINST OR PENALIZED BY US FOR FILING A COMPLAINT.

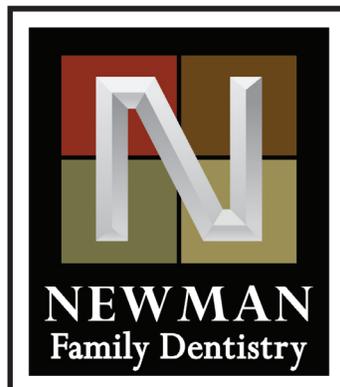
## SIGNATURE REQUIRED

Your signature is required below indicating that the entirety of Newman Family Dentistry Privacy Practices Policy has been shared with you. By signing, you also acknowledge that an actual copy of this policy as been offered to you as well. This signature page will be maintained in your records and a copy will be provided to you upon request.

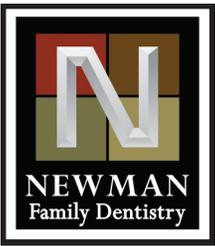
Patient/Guardian Signature: \_\_\_\_\_

Patient/Guardian Name – Printed: \_\_\_\_\_

Date: \_\_\_\_\_



Revised 1-25-2020



# FINANCIAL RESPONSIBILITY

## FINANCIAL RESPONSIBILITY AGREEMENT

Our credit policies have been established to ensure that the best services can be provided to you and your family and any misunderstandings can be avoided.

Our professional services are rendered to the patient and not to the insurance company. The insurance company is responsible to the patient and the patient is responsible to the doctor. You are responsible for the payment of any and all bills not covered by or paid for by your insurance company.

For your convenience, our office has made arrangements with **Care Credit** to offer low monthly payments with fixed or no interest fee plans. Ask our front office staff for assistance applying.

We believe our fees give an excellent value for the high quality and variety of services we provide. That said, please remember that what insurance companies call "Usual and Customary Fees" can vary widely with the dental plans offered by your employer and by which plan the employee selects.

## PAYMENT IS DUE AND PAYABLE AS SERVICES ARE RENDERED

**TREATMENT PLANS:** All treatment plans given by Newman Family Dentistry are an ESTIMATE only. If you want a guaranteed price, we can submit a pre-determination to your insurance company.

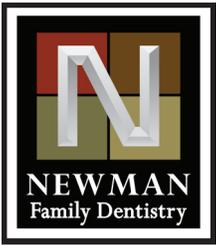
**INTEREST:** We reserve the right to charge interest in the amount of 1.5% per month as provided by state law, or a billing fee of \$12.50 on accounts 30 days or older.

**CANCELLATION AND FAILED POLICY NOTICE:** Due to an increase in demand for appointments, and to help better serve all our patients, we have implemented a "Cancellation and Failed Appointment Policy." Effective immediately, all cancellations require a 24 HOUR NOTICE. If we are not given proper notice, there will be a \$35.00 charge added to your account. A failed appointment (a missed appointment without any notice) will result in a \$50.00 charge added to your account.

In consideration of treatment required, I accept full financial responsibility. Insurance forms will be completed as a courtesy to the patient; however, your estimated payment not covered by insurance is expected on the date of services/treatment rendered unless prior arrangements are made. I further agree that if this account is turned over to an attorney or collection agency, I will be responsible for all collection fees, attorney fees, and interest and court costs. I also agree to assign any and all insurance benefits to be paid directly to Don M. Newman, D.D.S., P.C. (Newman Family Dentistry).

## I HAVE READ THIS FINANCIAL AGREEMENT. I UNDERSTAND AND AGREE TO THIS FINANCIAL AGREEMENT

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# CONSENT FOR FRENECTOMY

## DIAGNOSIS:

After a careful oral examination and study of my (or my child's) mouth, I have been advised that the examination demonstrates abnormal tension/shortened bands under the tongue, central upper lip or other areas in the mouth and that these bands may be related to symptoms being experienced.

## RECOMMENDED TREATMENT:

In order to treat this condition, the doctor has recommended a procedure to release the tight bands (Frenectomy). I understand that a topical numbing gel will be utilized and an injected local anesthetic may be administered to me as part of the treatment. Vitamin K is a recommended treatment prior to undergoing any infant surgical procedure - the lack of vitamin K is associated with increased rates of neonatal hemorrhage.

## PRINCIPAL RISKS AND COMPLICATIONS:

I understand a small number of patients experience problems after the procedure.

Risks include:

- Pain
- Bleeding (especially if vitamin K has not been administered)
- Infection
- Numbness
- Damage to saliva glands (resulting in blockage or ranula) and/or saliva ducts
- Damage to underlying structures (ie: muscle and nerve fibers, blood vessels, etc.)
- Aversion to any feeding
- Reattachment of the bands causing return of symptoms
- Failure to improve
- Need for repeat surgery or other surgeries (to treat complications)

## NECESSARY FOLLOW-UP CARE AND SELF-CARE:

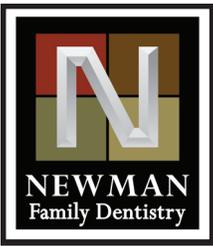
I understand that failure to follow recommendations could lead to ill effects, which is my sole responsibility. I know it is important to abide by the specific instructions given by the doctor. Continued involvement with your lactation consultant, speech pathologist, myofunctional therapist or other health care professional is mandatory and critical in improving symptoms.

I have asked all of my questions and have had time to discuss options with my surgeon.

By signing, I elect to proceed with the procedure for myself (or my child).

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# TONGUE/LIP TIE PATIENT REGISTRATION

Patient's Name: \_\_\_\_\_ Parent's Names: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Patient's DOB: \_\_\_\_\_

Pediatrician's Name \_\_\_\_\_ Hospital/Place of delivery: \_\_\_\_\_

Are you currently working with a lactation consultant?  Yes  No

If so, who? \_\_\_\_\_ Where? (hospital/private) \_\_\_\_\_

Is your infant currently being seen for bodywork (chiropractor, physical therapist, osteopath, occupational therapist, other)?  Yes  No

If yes, what type and by whom? \_\_\_\_\_

## MEDICAL HISTORY

Birth weight (lb/oz): \_\_\_\_\_ Most current weight and date (lb/oz): \_\_\_\_\_

Food allergies?  Yes  No If yes, which food(s): \_\_\_\_\_

Medication allergies?  Yes  No If yes, which medication(s): \_\_\_\_\_

List all current maternal medications/supplements: \_\_\_\_\_

List all current infant medications/supplements: \_\_\_\_\_

Was your infant premature?  Yes  No If yes, gestational age at birth: \_\_\_\_\_

Did your infant receive a Vitamin K shot?  Yes  No

Does your infant have any heart disease?  Yes  No

Has your infant had any surgeries?  Yes  No If yes, what type(s) and when: \_\_\_\_\_

Has your infant had prior surgery to correct a tongue or lip tie?  Yes  No

If yes, please specify which area(s) of the mouth and who performed the procedure: \_\_\_\_\_

Does your child have any other medical conditions?  Yes  No

If yes, please explain: \_\_\_\_\_

## PREGNANCY/LABOR HISTORY

Please check any that applied:

Long Labor /Excessive Pushing  Breech Birth  Unplanned C-Section  Trauma from Vacuum or Forceps

If you have any other labor complication(s), please explain: \_\_\_\_\_

## MODE OF FEEDING

Is this your first time breastfeeding?  N/A  Yes  No Are you currently using a nipple shield?  Yes  No

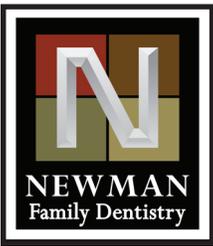
Other breastfed children/how long? \_\_\_\_\_ How would you rate your milk supply?

Are you supplementing with pumped breast milk?  Yes  No  Oversupply  Good  Fair  Poor

If yes, how many bottles/ounces per day? \_\_\_\_\_ On average, how long does it take to feed your child? \_\_\_\_\_ min.

Are you supplementing with formula?  Yes  No Have you done any pre- and post-feeding weight checks?  Yes  No

If yes, how many bottles/ounces per day? \_\_\_\_\_ If so, how much was transferred? \_\_\_\_\_ oz.



# TONGUE/LIP TIE PATIENT INFORMATION

What are the main concerns that brought you in today? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## BABY'S SYMPTOMS

- Does your infant pop on and off the breast or bottle while feeding?  Yes  No
- Does your infant struggle to stay awake while nursing?  Yes  No
- Does milk or formula leak or spill out the side of the mouth while actively feeding at breast or bottle?  Yes  No
- Does your infant have a history of poor weight gain?  Yes  No
- Does your infant chomp and gum on your nipples while feeding?  Yes  No
- Does your infant become fussy or fight you at the breast?  Yes  No
- Does your infant's upper lip remain tucked in while feeding at breast or bottle?  Yes  No
- Is your infant very gassy?  Yes  No
- Has your infant been diagnosed with GERD (reflux)?  Yes  No
- Is your infant experiencing colic?  Yes  No
- Do you hear a "clicking" noise while feeding?  
 If yes, is it frequent?  Yes  No
- Does your infant use a pacifier?  
 If yes, does it frequently pop out?  Yes  No

## MOTHER'S SYMPTOMS

Using a scale from 0-10, with 10 being the highest, how would you rate your discomfort while breastfeeding? \_\_\_\_\_

Please check any of the following that best describes your breasts or nipples after feeding (B=Both | R=Right | L=Left):

- |                       | B                     | R                     | L                     |                 | B                     | R                     | L                     |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------|-----------------------|-----------------------|-----------------------|
| Creased .....         | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Cracked .....   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Flattened .....       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Bruised .....   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Lipstick-Shaped ..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Blistered ..... | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Blanched White .....  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Bleeding .....  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

- Are you experiencing poor or incomplete breast drainage?  Yes  No
- Do you have a history of, or currently have, mastitis?  Yes  No
- Do you have a history of, or currently have, nipple/infant oral thrush?  Yes  No