DAYSPRING DENTAL

DATE: _____

INFANT|PATIENT INFORMATION

Patient's Name: _____ Preferred Name: _____

D.O.B: _____ Gender: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____

PARENT|LEGAL GUARDIAN INFORMATION

Parent/Legal Guardian (Full Name): _____ D.O.B: _____

Relationship: _____ Cell Phone #: _____

Email: _____

Employer: _____ Years Held: _____

Present Work Position: _____ Work Phone #: _____

Business Address: _____ City: _____

State: _____ Zip Code: _____

Parent/Legal Guardian (Full Name): _____ D.O.B: _____

Relationship: _____ Cell Phone #: _____

Email: _____

Employer: _____ Years Held: _____

Present Work Position: _____ Work Phone #: _____

Business Address: _____ City: _____

State: _____ Zip Code: _____

PREFERRED METHOD OF CONTACT (Please circle all that apply below)

Home Phone Cell Phone Text Email

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INSURANCE INFORMATION

Primary Company: _____ Policy/Group #: _____

Policy Holder: _____ D.O.B: _____

Policy Holder SS/ID #: _____

Address Of Company: _____ Phone #: _____

_____

Secondary Company: _____ Policy/Group #: _____

Policy Holder: _____ D.O.B: _____

Policy Holder SS/ID #: _____

Address Of Company: _____ Phone #: _____

_____

Who will pay this account? _____

HOW DID YOU HEAR ABOUT US? (Please circle all that apply below)

Website Drive By Facebook Health Provider Friend Other

- Please specify: _____

DAYSPRING DENTAL

INFANT|PATIENT INFORMATION

Patient's Name: _____ D.O.B: _____

Gender: _____

Name of Parent(s): _____

_____

HEALTH PROVIDER/LACTATION CONSULTANT

Child's Pediatrician: _____ Phone #: _____

Mailing Address: _____ City: _____

State: _____ Zip: _____

Lactation Consultant: _____ Phone #: _____

What are your main concerns/symptoms? _____

Is this your first child? Y N

- If no, birth order: 2nd 3rd 4+

Any feeding issues with previous babies? Y N N/A

- If yes, please explain: _____

Has anyone on either side of the family had a lip/tongue tie? Y N

- If yes, who? _____

Have there been any congenital defects and/or injuries to the face or mouth? Y N

- If yes, please explain: _____

Does your child suck their thumb or finger(s)? Y N

Does your child use a pacifier? Y N

DOES YOUR CHILD…

Have any disease, condition, or problem not listed that we should be aware of? Y N

- If yes, please list: _____

Have any known allergies? Y N

- If yes, please list: _____

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DOES YOUR CHILD… (CONT)

Take any drug/medication(s)? Y N

- If yes, please list: _____

Take any vitamins, supplements, or homeopathic remedies? Y N

- If yes, please list: _____

Has your child ever been hospitalized or had surgery? Y N

- If yes, please explain: _____

PREGNANCY/LABOR/DELIVERY

Any complications during pregnancy? Y N

- If yes, please explain: _____

Was your child delivered by Caesarean Section? Y N

Any complications during labor/delivery or after? Y N

- If yes, please explain: _____

Child was born at _____ weeks

Child's birth weight: _____

current weight: _____

Did your child receive Vitamin K injection at birth? Y N

Date of last physical exam: _____

FOR MOM

Any underlying medical condition(s)? Y N

- If yes, please list: _____

HAVE YOU HAD…

Nipple thrush?	Y	N	Infected nipples?	Y	N
Plugged ducts?	Y	N	Mastitis?	Y	N
Engorged/Unemptied breasts?	Y	N	Breast/Nipple abnormalities?	Y	N

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CHILD'S NAME: _____ MOM'S NAME: _____

FEEDING EVALUATION

How are you currently feeding your baby? (Please check all that apply)

- ▢ Exclusively breastfeeding
- ▢ Breastfeeding supplemented w pump breast milk
- ▢ Breastfeeding supplemented w formula
- ▢ Exclusively bottle-feeding pumped breast milk
- ▢ Exclusively bottle-feeding breast milk and formula
- ▢ Exclusively bottle-feeding formula

Are you using a nipple shield? _____

What is your feeding goal for this baby? _____

DOES MY BABY HAVE LIP/TONGUE TIE?

Complete the survey below by answering each question with a score ranging from 1 to 5, and scoring yourself at the bottom.

	Strongly Disagree				Strongly Agree
Nursing my baby is painful	1	2	3	4	5
Nursing my baby is frustrating	1	2	3	4	5
My nipples have cracked or bled after nursing	1	2	3	4	5
My nipples are pinched after nursing	1	2	3	4	5
I have cried because of my nursing problems	1	2	3	4	5
My milk supply has gone down	1	2	3	4	5
My baby feeds for long periods of time	1	2	3	4	5
My baby falls asleep at the breast	1	2	3	4	5
My baby has a lot of gas/reflux	1	2	3	4	5
My baby has morning congestion	1	2	3	4	5
My baby makes clicking sounds while nursing	1	2	3	4	5
My baby leaks milk while nursing	1	2	3	4	5

YOUR SURVEY SCORE: _____

DAYSPRING DENTAL

FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you with the best possible care. If you have dental insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Payment of services is due at the time services are rendered. If you have dental insurance, you must make the estimated co-payments at the time of treatment, and you are completely responsible for anything the insurance company does not want to pay within 45 days after billing. We accept cash, personal checks, Visa, Mastercard, Discover and American Express. We also offer Care Credit, interest free financing for your choice of 3, 6, 12, or 18 months upon qualifying. Please ask for an application if you are interested. Returned checks or balances older than 30 days may be subject to additional collection fees. Charges may also be made for missed appointments and appointments canceled without 24 hours advance notice.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a Party to that contract.

2. Not all services are a covered benefit in all contracts. Some insurance companies select services they will not cover. You become financially responsible for these services.

3. Please be advised that this office does not place silver fillings in posterior (back) teeth. We only place white composite filling material, 99% of all insurance companies only allow for amalgam (silver) filling material, but will pay an alternate benefit for the silver. This means you, the patient then becomes responsible for any difference.

4. In cases of divorce or separation with children involved it is our office policy that the parent who has residential custody is responsible for paying any co-payment and/or deductible at the time of service. If insurance is involved and they pay less than expected, again the parent with residential custody is responsible for the balance. We will give the parent receipts to obtain reimbursement from other parties involved.

DAYSPRING DENTAL

FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE (CONT)

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. The filing of insurance claims is a courtesy we extend to our patients; all charges are your responsibility from the date services are rendered. If financial problems do arise we encourage you to contact our office promptly so that we may help you with the management of your account.

Again, thank you for selecting Dayspring Dental for your dental needs. If at any time you have a question regarding your treatment, fees or services, please contact us promptly to discuss.

By signing this paper you agree to and fully understand our payment policy.

_____ _____

Signature Date

If you have dental insurance please sign and date below as "Signature on File" so that we may manually or electronically submit your dental claims on your behalf.

_____ _____

Signature Date

DAYSPRING DENTAL

PAYMENT OPTIONS

We feel that it is very important for us to provide you with the treatment that is wanted and needed, therefore, we have several payment options available for your convenience. Please indicate which option(s) will work best for you.

INSURANCE:

- ▢ I do not have insurance to cover your fees.
- ▢ I have insurance coverage and would like you to file my claim and charge me for my estimated portion at the time of service.
- ▢ I have insurance coverage and will pay you directly then file my own claims for reimbursement.

OTHER PAYMENT:

I recognize that I am responsible for all fees related to my treatment. For that portion not covered by my insurance I will pay by:

- ▢ Cash or Check
- ▢ Visa, MasterCard, American Express, Discover or Debit Card
- ▢ Care Credit
    - ▢ I have one, my account # is _____
    - ▢ I wish to apply
- ▢ Lending Club
    - ▢ I have one, my account is # is _____
    - ▢ I wish to apply

_____ _____ _____

Patient's Name (Please Print) Signature Date

DAYSPRING DENTAL

MAY WE SHARE YOUR PHOTOS?

- ☐ Facial Photo
- ☐ Mouth and/or Teeth
- ☐ Use of both listed above
- ☐ Educational purposes only
- ☐ On Our Website
- ☐ On Dayspring Dental's Facebook/Instagram

_____	_____	_____
Patient's Name (Please Print)	Signature	Date

DAYSPRING DENTAL

NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT

Privacy Officer,

DATE: _____

PATIENT NAME: _____

D.O.B: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides, in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

Understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of PRivacy Practices on request.

_____ _____

Signature Date

_____

Relationship to Patient
(if signed by a personal representative of patient)

DAYSPRING DENTAL

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means such as sending correspondence to the individual's office instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (Please check all that apply)

- ▢ Home Phone
  - ▢ OK to leave message with detailed information
  - ▢ Leave message with call-back number only
- ▢ Work Phone
  - ▢ OK to leave message with detailed information
  - ▢ Leave message with call-back number only
- ▢ Written Communication
  - ▢ OK to mail to my home address
  - ▢ OK to mail to my work/office address
  - ▢ OK to fax to this number _____
- ▢ Other _____

_____ _____

Patient's Signature Date

_____ _____

Print Name D.O.B

The privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

DAYSPRING DENTAL

PATIENT RECORD OF DISCLOSURES (CONT)

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

DATE	DISCLOSED TO WHOM ADDRESS/FAX NUMBER	DESCRIPTION OF DISCLOSURE/PURPOSE OF DISCLOSURE	BY WHOM DISCLOSED

DAYSPRING DENTAL

POST FRENECTOMY THERAPY FOR INFANTS

As with any cut, your baby's body wants to heal the released tissue back together and make it as it was before the procedure. Even though the frenectomy released abnormal attachments that were causing problems, your baby's body doesn't realize this yet and it wants to put everything back together exactly how it was. This is not what we want. We want the frenectomy site(s) to heal in a new way to allow for increased mobility and function. A multidisciplinary team of tongue-tie experts from around the world has developed a protocol for post frenectomy therapy to assist this. This has been developed through the clinical experience of many providers and has demonstrated improved outcomes.

1. Wash hands
2. Lay baby on their back with their head towards you and feet away from you. It can be helpful to swaddle baby and roll a hand towel or receiving blanket and place it behind baby's neck. This helps his head flex back making it easier to get into their mouth.
3. Bring the tips of both pointer or index fingers together and slide them under baby's tongue with the pads of your fingers firmly pressing towards the base of the baby's tongue. Your fingers should now be directly on the frenectomy site. Using a motion that both presses back into the base of the tongue and lifts the tongue up towards the roof of the mouth, sweep your fingers up and down swiftly for about 5 strokes.
4. With fingers in the same position as previously described, while still pressing into the frenectomy site, rub them firmly but gently from side to side for a few strokes.
5. If your baby also had an upper lip tie released, repeat steps 3 and 4 on the frenectomy site.
6. Repeat these stretching exercises 3 to 5 times per day.

The goal of this therapy it to keep the tissue healing in an open or seperated manner without the released tissue healing back together. Being diligent with the therapy will help reduce the risk of this happening. It is not necessary to take a long time to do the stretches. It is best to get in and out quickly, but be sure you are effectively separating the tissues when doing the stretches. Particularly in the first few days following the procedure(s), it is normal to see a bit of bleeding, especially if there has been some re-attachment. Breastfeeding your baby will help any bleeding stop. If it is more than a little bleeding, please call your provider for guidance.

DAYSPRING DENTAL

POST FRENECTOMY THERAPY FOR INFANTS (CONT)

Be sure to incorporate pleasant oral work too which will encourage development of better tongue function: tickle baby's lower lip with your finger, this encourages them to stick their tongue out. Slide your finger along baby's lower gums from one side to the other, encouraging them to open wide. Once opened wide, slide your finger in their mouth, pad up, on top of their tongue and allow them to suck. While baby sucks and you press down on their tongue slightly, gently play tug-of-war, pulling your finger out slightly and letting baby work to suck your finger back in. This can be especially helpful just before baby breastfeeds since it helps baby learn proper tongue movement needed for breastfeeding. These pleasant exercises can be repeated many times per day.

If you are using pharmaceutical medications for pain, you can time them so they will be at peak effect for therapy sessions. For most babies, the first two to three days are the most intense and then the discomfort subsides considerably. Continue the therapy for 2 to 3 weeks and the area becomes completely pink, like the rest of the baby's mouth.

Take note of what the incision(s) look like immediately after the procedure, watch for any changes to the shape. The edges of the diamond should stay sharp. If they begin to look muddled or "tucked in", or you see tissue protruding from the rest, there may be reattachment starting. Be sure to pay extra attention to this area, using a slightly firmer pressure during therapy sessions. You will likely be able to release it yourself with the fingers. (It may bleed a little, that's okay, just breastfeed/feed your baby).

If you have any questions or concerns please contact Dr. Kathleen J. Bickel, D.M.D through our office at 856-875-8400 or if the office is closed, the emergency line at 609-221-2965.

https://www.youtube.com/watch?v=62pZw0LqYv8 ; link to "Care after lingual and maxillary lip ties have been revised for breastfeeding infants" by Dr. Lawrence Kotlow.

POST OP MEDICATIONS FOR INFANTS

UNDER 6 MONTHS OF AGE

Tylenol only - Infant / Children's suspension

6-11 lbs: 1.25 mL

12-17 lbs: 2.5 mL

18-23 lbs: 3.75 mL

Give every 4 hours as needed. Do not exceed 5 doses in 24 hours.

DAYSPRING DENTAL

FRENECTOMY INFORMED CONSENT FORM

PATIENT NAME: _____

Diagnosis: After a thorough oral examination, Dr. Bickel has advised me that revision of frenum(s) in my child's mouth may help to restore anatomy, function and/or possibly prevent commonly associated future problems.

Recommended Treatment: In order to treat this condition, Dr. Bickel has recommended that a frenectomy be performed at the selected site(s). An all tissue laser will be utilized. This very laser is FDA approved for this soft tissue surgery and is an excellent tool to optimize treatment and recovery.

Principle Complications: I understand that a smooth recovery is expected, however, there are always associated risks that cannot be eliminated and may occur in a minority of cases. These complications include but are not limited to post-surgical bleeding, infection, swelling, pain, damage to adjacent structures such as salivary glands, nerve, muscle and skin. A more common complication is re-attachment of the frenum. Genetics also plays a strong role in healing, such as formation of scar, keloid, or overt fibrous tissue formation.

Follow Up: I am advised to return for a 1 week follow up for Dr. Bickel to check the area(s). Before and after photos will be taken of your child's mouth, but will not be shared without permission.

Alternatives to Suggested Treatment: I understand that alternatives to a frenectomy include: no frenectomy, with the expectation that the frenum does not normally improve with age but may aggravate the surrounding tissues including the gums and teeth.

No Warranty or Guarantee: I hereby acknowledge that no guarantee, warranty or assurance has been given to me that the proposed treatment will be successful. I do expect however that the doctor perform the surgery to the best of her ability.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT AND ALL MY QUESTIONS HAVE BEEN ANSWERED.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Doctor D.O.B