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

DAYSPRING DENTAL

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 experience hiccups? 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: _____

DAYSPRING DENTAL

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: _____

Has your child had a previous lip tie/tongue tie correction? Y N

- If yes, by whom and when: _____

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: _____

Are there any concerns about your child's weight gain? Y N

Did you refuse the 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

DAYSPRING DENTAL

DATE:_____

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? _____

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	N/A
Nursing my baby is frustrating	1	2	3	4	5	N/A
Bottle feeding my baby is frustrating	1	2	3	4	5	N/A
My nipples have cracked or bled after nursing	1	2	3	4	5	N/A
My nipples are pinched after nursing	1	2	3	4	5	N/A
I have cried because of my nursing/feeding problems	1	2	3	4	5	N/A
My milk supply has gone down	1	2	3	4	5	N/A
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	N/A
My baby falls asleep at the bottle	1	2	3	4	5	N/A
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	N/A
My baby makes clicking sounds while bottle feeding	1	2	3	4	5	N/A
My baby leaks milk while nursing	1	2	3	4	5	N/A
My baby leaks milk/formula while bottle feeding	1	2	3	4	5	N/A

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)

- ▢ Cell Phone
  - ▢ OK to receive text messages
  - ▢ OK to leave voicemail with detailed information
  - ▢ Leave voicemail with call-back number only

- ▢Home 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.

DAYSPRING DENTAL

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

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 CARE 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 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. Wait until 6 hours after the procedure to begin the stretches.

1. Wash hands/Use latex free gloves. 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 the neck extend making it easier to get into the mouth.
2. It is important to stretch all areas that have been released, that may be lip, cheeks, and/or tongue 3 times a day for 4 weeks.

   Lip stretch - Grasp the upper lip with your thumbs and index fingers. Lift up toward the nose to see the entire inside of the lip.

   Cheek stretch - Massage the upper inside of one cheek and then the other. It is helpful to switch hands. Right index finger massages left cheek and left index finger massages the right cheek.

   Tongue stretch- With your non-dominant hand, stabilize baby's jaw with your thumb on baby's gums and fingers under the chin. Slide your opposite index finger from the center of the lower gums straight down to the floor of the mouth and then sweep under the tongue. Do this 3 times using firm pressure.

   The goal of this therapy is to keep the tissue healing in an open or separated manner without the released tissue sticking back together and becoming tight once again. Quality stretches are critical for proper healing. It is not necessary to take much time doing the stretches. It is best to get in and out quickly, but be sure you are effectively separating the tissues when doing the stretch. Expect some extra drooling. Usually there is minimal to no bleeding after the procedure. You may see bleeding if there has been some reattachment of the tissue and you were able to stretch it open again. This may also occur at your post op visit. Breastfeeding your baby should help the bleeding to stop. If it is more than a little bleeding, please call your provider for guidance. If there is profuse bleeding, put direct pressure on the wound for 10 minutes. If you

are unable to control after using pressure on the area, please seek emergency assistance at a pediatric emergency facility.

POST FRENECTOMY CARE FOR INFANTS (CONT)

In addition, you may incorporate pleasant oral work which will encourage development of better tongue function: tickle baby's lower lip with your finger, this encourages them to stick their tongue out. Slowly slide your finger along baby's lower gums from one side to the other, encouraging them to move the tongue side to side. Tap baby's lower lip and once the mouth opens, slide your finger in their mouth, index finger pad up, and allow them pull your finger in and suck. While baby sucks and you press down on their tongue slightly, gently play tug-of-war, pulling your finger out slightly and let baby work to suck your finger back in. This can be especially helpful just before baby breastfeeds as it helps baby learn proper tongue movement needed for breastfeeding. These pleasant exercises can be repeated several times per day.

If you are using medication for pain, try to time it so it will be at peak effect during the stretches. For most babies, the first 24 hours are the most uncomfortable. After a few days, discomfort subsides considerably. This does not mean that baby will no longer be annoyed during the stretches.

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 new tissue fibers forming, there may be reattachment starting. Be sure to pay extra attention to this area, using a slightly firmer pressure during stretches. You will likely be able to release it yourself with your fingers, but expect some bleeding.

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, text Dr. Kathy directly at 609-221-2965.

POST OP MEDICATIONS FOR INFANTS

Infants Tylenol

6 lbs-1.25 ml

7 lbs- 1.5 ml

8 lbs- 1.75 ml

9 lbs- 1.9 ml

10 lbs- 2.1 ml

11 lbs 2.3ml

12-14 lbs- 2.5 ml

DAYSPRING DENTAL

15-17 lbs- 3.0 ml

18-23 lbs 3.75 ml

Give every four hours as needed. Do not exceed five doses in 24 hours.

Alternatively, you may use Hyland's Homeopathic remedy for infants.

FRENECTOMY INFORMED CONSENT FORM

PATIENT NAME: _____

Diagnosis: After a thorough oral examination, Dr. Bickel has advised me that revision of frenum(s) ____tongue ____lip ____cheeks 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). A medical/dental laser will be utilized. The 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 role in healing, such as formation of scar, keloid, or overt fibrous tissue formation. Also, this surgical procedure is usually part of a team treatment approach which may involve a feeding specialist and/or a bodyworker.

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 and 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 have been advised to seek complementary therapy for the best outcome of this procedure.

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

DAYSPRING DENTAL

_____	_____
Signature of Parent/Guardian	Date
_____	_____
Signature of Doctor	Date