PA Tongue-Tie Center

Subsidiary of: East Berlin Smiles

Full Name *

First Name Last Name

Email

example@example.com

Birth Date *

mm-dd-yyyy

Date

Today's Date *

05-04-2021

Date

Present Weight *

Who diagnosed the lip/tongue tie in your child? *

Prefix First Name Last Name

Who referred you to our office? *

Prefix First Name Last Name

Do you have a lactation consultant you are currently working with? *

- Yes
- No

Name of Lactation Consultant

First Name Last Name

Medical History:

Was your infant premature? *

- Yes
- No

Has your infant had significant medical problems? *

- Yes
- No

Is your infant taking any medications? *

- Yes
- No

Did your infant have the Vitamin K shot at birth? *

- Yes
- No

Has your infant experienced any of the following? *

- [ ] Shallow latch
- [ ] Falls asleep while attempting to latch
- [ ] Colic or Reflux – Gassy, hiccups, spit up
- [ ] Frequently comes off while feeding
- [ ] Clicking/Popping sound
- [ ] Long nursing sessions
- [ ] Baby leaks milk while feeding at the breast or bottle
- [ ] Poor weight gain
- [ ] Seems frustrated when feeding
- [ ] Short sleep episodes

Do you have any of the following symptoms? *

- [ ] Creased or flattened nipples after nursing
- [ ] Cracked, bruised or blistered nipples
- [ ] Severe pain while your infant attempts to latch
- [ ] Plugged milk ducts
- [ ] Mastitis or nipple thrush
- [ ] Poor or incomplete breast drainage

Breast Feeding History *

- [ ] Using a nipple shield
- [ ] Supplementing with formula or pumped breastmilk
- [ ] Is this your first child? Do any other children have ties?

Insurance

If you do not have insurance you may skip this section

Do you have Dental Insurance? *

- ○ Yes I have insurance, continue
- ○ No I do not have insurance, skip

Insurance Co. Name: *

Insurance Claim's Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Insurance Co. Phone Number *

–

Area Code Phone Number

Group # (Plan, Local or Policy #): *

Subscriber's Name: *

First Name Last Name

Subscriber's Date of Birth

mm-dd-yyyy

Date

Subscriber's ID or Social Security #: *

Employer: *

Secondary Dental Insurance

You may skip this section if it does not apply to you *

- I have Secondary Dental Insurance, continue
- I do not have Secondary Dental Insurance, skip

Insurance Co. Name: *

AddressInsurance Claim's Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Insurance Co. Phone Number *

Area Code – Phone Number

Group # (Plan, Local or Policy #): *

Subscriber's Name:

First Name Last Name

Subscriber's Birthdate: *

mm-dd-yyyy

Date

Subscriber's ID or Social Security #: *

Employer: *

Informed Consent for Infant Oral Surgery

Prior to completing any oral care on your infant, we require your consent for treating your child. It is the philosophy of our office to provide children the highest quality of care in a manner which is as pleasant and safe as possible. During treatment on small infants, it may be necessary for your infant to be swaddled or placed in a similar protective appliance to control undesirable movements. There may be the need for Dr. Cockley to numb

the surgical area using a small amount of topical or local anesthetic and to provide adequate visibility and access to the surgical areas using a comfortable mouth prop.

Older infants may require some type of oral premedication, which if needed, will be discussed prior to having any child sedated. The purpose of all these procedures is to gain and maintain good oral health, successful breastfeeding, reducing maternal discomfort and, in many instances, future problems that may be associated with tongue and or lip-ties.

Dr. Cockley anticipates good results; however, no guarantees as to the results are given. Laser treatment usually proceeds as planned; however, as in all areas of medicine, results cannot be guaranteed, nor can all consequences be anticipated. Post-surgical discomfort may be minimal or last as long as a week before our goals are met. Bleeding is always a rare possibility; however, we have not experienced any significant problems that would indicate any serious risks of the surgery. Not treating existing dental problems in children may result in continuing breastfeeding problems. Successful breastfeeding is our primary goal for today's surgery. Parents and guardians should understand recommended procedures, alternative options and anticipated results.

Surgery for tongue-tie and lip-tie for infants in this office is completed using appropriate laser technology, which has proven safe for infants as well as all patients. Successful results of this surgery are dependent on parents following carefully all post-operative recommendations for keeping the surgical sites from healing together, seeing their lactation consultant and, if indicated, a craniosacral therapist.

Acknowledgment of Informed Consent

I hereby acknowledge that I have been fully informed as to the treatment considerations. I have read and understand this form. I understand the advantages and disadvantages of treatment as well as alternative means of completing these procedures. This office has explained the purpose of the

surgery through a consultation involving oral discussions and written information. I have been given the opportunity to ask Dr. Cockley all questions I have about the proposed surgical treatment. All questions and concerns have been discussed. I give my free and voluntary informed consent for treatment to be completed. I release Pennsylvania Tongue Tie Center/East Berlin Smiles to use any dental/therapy photographs or videos for lecturing, promotional, marketing, or educational purposes. By signing this consent, I indicate that I have the legal authority to grant this permission. I have given Dr. Cockley a complete medical history of my child.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

• Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples would be teeth cleaning services, extraction letters, and periodontal or endodontic referrals.

• Payment means such activities as obtaining reimbursement for services, confirming coverage, and obtaining specific benefit information such as benefit maximums and deductibles met, etc., billing or collection

activities, and utilization review.

• Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individual identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

• The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

• The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

• The right to inspect and copy your protected health information.

• The right to amend your protected health information.

• The right to receive an accounting of disclosures of protected health information.

• The right to obtain—and we have the obligation to provide—a paper copy of this notice from us at your first delivery of services date.

• The right to provide—and we are obligated to receive—a written acknowledgement that you have received a copy of our Notice of Privacy Protection Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health.

This notice is effective as of April 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that our privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of their provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

East Berlin Smiles Dental Center

418 West King Street East Berlin, PA 17316

(717) 259-9596

www.EastBerlinSmiles.com

For more information about HIPAA or to file a complaint:

The U. S. Department of Health & Human Services Office of Civil Rights

200 Independence Avenue, SW Washington, DC 20201 202-619-0257

Toll Free: 1-877-696-6775

Child's Name

Parent's Signature

Clear

Today's Date

05-04-2021

Date

Finish