Pennsylvania Tongue Tie Center

Subsidiary of: East Berlin Smiles

Child's Name *

First Name

Last Name

Address *

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Email

example@example.com

Date of Birth *

MM-DD-YYYY

Date

Mother's Date of Birth

MM-DD-YYYY

Date

Today's Date *

05-04-2021

Date

Who diagnosed your child's lip/tongue tie? *

First Name

Last Name

Who referred your child to our office? *

First Name

Last Name

Pediatrician / Doctor's Phone Number *

(000) 000-0000

Please enter a valid phone number.

Medical History:

Has your child had any medical problems? *

- Yes
- No

Is your child taking any medications? *

- Yes
- No

Did your child struggle with breastfeeding? *

- Yes
- No

Has your child experienced any of the following? *

- [ ] Speech delay/trouble speaking
- [ ] Choking/Gagging
- [ ] Clenching/Grinding teeth
- [ ] Belly problems (Ex: reflux, gassy)
- [ ] Constipation
- [ ] Neck tension/Posture problems
- [ ] Headaches
- [ ] Chronic ear infections
- [ ] Bedwetting
- [ ] Avoiding textures/meat
- [ ] Dental problems (Cavities)
- [ ] Snoring
- [ ] Drinking a lot of water during meals
- [ ] Scooping food out with fingers
- [ ] Messy eater
- [ ] Loud eater
- [ ] Slow eater
- [ ] Uncontrolled salivation/drooling

Additional Comments:

Type here...

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 Claims Address *

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Insurance Co. Phone Number *

(000) 000-0000

Please enter a valid 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: *

Insurance Claims Address *

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Insurance Co. Phone Number *

(000) 000-0000

Please enter a valid phone number.

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

Subscriber's Name: *

Subscriber's Birthdate: *

MM-DD-YYYY

Date

Subscriber's ID or Social Security #: *

Employer: *

Informed Consent for Oral Surgery

Diagnosis: After a thorough oral examination, my child's dentist has advised me that the revision of a frenum in my child's mouth may help to restore anatomy, function, and/or prevent commonly associated future problems. Recommended Treatment: In order to treat this condition, my child's dentist has recommended that a frenectomy be performed at the selected site or sites. A soft tissue laser will be utilized. This 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, swelling, tenderness, discomfort, damage to adjacent structures such as salivary glands, nerve, muscle, or 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 may be advised to return for an appointment to follow up on the proposed care. There may be a referral to a myofunctional therapist for supportive therapy. Photos may be taken.

Alternatives to Suggested Treatment: I understand that alternatives to a frenectomy include: no frenectomy, with the expectation that the frenum does not normally improve but may aggravate the surrounding tissues including the gums and teeth. Also, an alternative to a frenectomy by my dentist is to seek the care of another health care professional, including but not limited to doctors of periodontics, oral surgery, ENT, and plastic surgery. The use of the laser itself can be deferred to more traditional instruments of care.

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.

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

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

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

I release Pennsylvania Tongue Tie Center/East Berlin Smiles to use any dental/therapy photographs or videos for lecturing, promotional, marketing, or educational purposes. I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT AND ALL MY QUESTIONS WERE ANSWERED.

Signature of Patient or Parent/Guardian

Clear

Date

05-04-2021

Date