INFANT FRENOTOMY QUESTIONAIRRE

Date of Visit:

Patient's Name:	Birthdate:	Male/Female:
Mother's Name:	Birthdate:	Number of Children:
Pediatrician/ARNP:		□ Referral
Lactation Consultant/Doula:		□ Referral

How did you hear about our services?

Whom may we thank for their referral?

Past Medical History

Birthplace: Pregnancy Complications? □ Yes □ No Delivery Complications? □ Yes □ No If Yes to either, describe:

Birth Weight (lb/oz): Present Weight: Was your infant premature? □ Yes □ No If Yes, gestation age (wks):

Received Vitamin K injections? □ Yes □ No Does your infant have any heart disease? □ Yes □ No If Yes, describe:

Has infant had prior surgery (circumcision, frenotomy, etc)? □ Yes □ No If Yes, describe:

Has infant passed hearing test? □ Yes □ No Medication Allergies? □ Yes □ No If Yes, describe: Current Medications?:

Infant's Symptoms

□ Poor Latch
□ Difficulty flaring upper lip
□ Lip blister noted
□ Clicking noted when nursing or bottle feeding
□ Slides off nipple when attempting to latch
□ Gumming or chewing of nipple when nursing
□ Unable to hold a pacifier in mouth
□ Falls asleep while attempting to nurse
□ Short sleep episodes requiring feeding every 2-3 hrs
□ Colic/Reflux Symptoms
□ Poor weight gain
□ History of Torticollis

Mother's Symptoms

□ Creased, flattened or blanched nipples after nursing
□ Cracked, bruised or blistered nipples
□ Bleeding nipples
□ Severe pain when your infant attempts to latch
□ Poor or incomplete breast drainage
□ Infected nipples or ducts
□ Plugged ducts
□ Mastitis or nipple thrush
□ Deficient milk supply
□ History of Reynaud's disease or vasospasm
□ Nipple anatomy variation limiting adequate milk delivery
□ Certain nursing positions/one breast easier to nurse than other

Have you been supplementing with formula? □ Yes □ No

Have you been using alternative forms of milk delivery? □ Yes □ No **If yes, what has been used?**

Family History of: □ **Tongue Tie** □ **Lip Tie** **Was it treated?** □ **Yes** □ **No**

Please describe which family member, when treated, how treated, and by whom?

Please describe anything else you'd like us to be aware of or evaluate:

Mother/Parent Signature: _____ Date: _____

SMALL TO TALL PEDIATRIC DENTISTRY

Olympia WA 98506
Phone: 360.459.5885 • Fax: 360.459.7115 • www.smalltotall.info

CHILD'S NAME _____ (Last) _____ (First) _____ (Initial)

☐ MALE ☐ FEMALE BIRTHDATE _____ AGE _____

HAS ANY OTHER IMMEDIATE FAMILY MEMBER BEEN TREATED AT THIS OFFICE? ☐ YES ☐ NO _____ (Name)

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

FATHER ☐ STEPFATHER ☐ GRANDFATHER ☐ LEGAL GUARDIAN ☐

_____ (Last) _____ (First) _____ (Initial)

SOCIAL SECURITY NO. _____ BIRTHDATE _____ ☐ Married ☐ Separated ☐ Divorced ☐ Single

ADDRESS _____ (Street or P.O. Box) _____ (City) _____ (State) _____ (Zip)

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ (Street or P.O. Box) _____ (Apt.) _____ (City) _____ (State) _____ (Zip)

DENTAL INSURANCE CO. _____ GROUP #/ID _____
(Info. Needed Only if Patient is Covered on This Policy)

ADDRESS _____ (Street or P.O. Box) _____ (Apt.) _____ (City) _____ (State) _____ (Zip)

Email Address: _____ Dad, Mom or Family? Home or Work?

MOTHER ☐ STEPMOTHER ☐ GRANDMOTHER ☐ LEGAL GUARDIAN ☐

_____ (Last) _____ (First) _____ (Initial)

SOCIAL SECURITY NO. _____ BIRTHDATE _____ ☐ Married ☐ Separated ☐ Divorced ☐ Single

ADDRESS _____ (Street or P.O. Box) _____ (City) _____ (State) _____ (Zip)

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ (Street or P.O. Box) _____ (Apt.) _____ (City) _____ (State) _____ (Zip)

DENTAL INSURANCE CO. _____ GROUP #/ID _____
(Info. Needed Only if Patient is Covered on This Policy)

ADDRESS _____ (Street or P.O. Box) _____ (Apt.) _____ (City) _____ (State) _____ (Zip)

IS THE PATIENT LISTED ABOVE COVERED UNDER THEIR OWN, SEPARATE INSURANCE POLICY? YES ☐ NO ☐

IF YES: NAME OF POLICY _____ ID# _____

POLICY BILLING ADDRESS _____ (Street or P.O. Box) _____ (City) _____ (State) _____ (Zip)

Assignment and Release: I hereby authorize the insurance benefits to be paid directly to the dentist. I also authorize the dentist to release any information required for all claims. I acknowledge that I am financially responsible for all charges whether or not they are paid by insurance. A minimum service charge of $1.00 (not to exceed 1%) on all charges over 90 days old will be accessed.

If I desire credit to be extended to me and/or my family for services rendered, I am aware that a credit report may be obtained before credit is extended.

In the event of default of payment and or/failure to pay, I agree to pay the costs of collection including court costs and reasonable attorney fees to be determined by a court of law. (I understand and agree that)...Any legal action, arising under or related to this agreement, shall be brought and maintained exclusively in a state court of Thurston County, State of Washington, and the parties hereby submit themselves to the personal jurisdiction and venue of those courts for the purpose of any such action and hereby waive any defense related to personal jurisdiction, process or venue brought in those courts.

SIGNED _____ **DATE** _____

Small To Tall Pediatric Dentistry
3422 12th Ave NE
Olympia, WA 98506

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Rowley and Ruder, PLLC's Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my child(ren)'s protected health information that might occur in his/her treatment, payment for services or in the performance of the office's health care operations. The Notice of Privacy Practices also describes my rights and Rowley and Ruder, PLLC 's duties with respect to my child(ren)'s protected health information. The Notice of Privacy Practices is posted in the facility.

Rowley and Ruder, PLLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my child(ren)'s first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my child(ren)'s protected health care information to the persons indicated below.				
My child(ren)'s other parent / step-parent / sibling	☐	YES	☐	NO
Grandparent or other child care provider	☐	YES	☐	NO
Other (please specify)	☐	YES	☐	NO

Name of Patient

Signature of patient or personal representative

Date

Relationship of Personal representative

OFFICE USE ONLY BELOW THIS LINE

RECORD OF ACKNOWLEDGEMENT NOT OBTAINED		
PROVIDED PRIOR TO TREATENT?	☐ YES ☐ NO	
DATE PROVIDED:		
REASON FOR DENIAL:	☐	NEEDED MORE TIME TO REVIEW NOTICE OF PRIVACY PRACTICES.
	☐	WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING.
	☐	UNABLE TO SIGN.
	☐	REASON NOT GIVEN.
	☐	OTHER (EXPLAIN):

Statement of Privacy Practices

Small to Tall Pediatric Dentistry

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your our obligations and your rights.

Protecting your Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Healthcare Information (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Healthcare Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI

Your Rights as our Patient

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

An expanded, and complete copy of our Statement of Privacy Practices, is available for your review.