Integrative Dental OF DENVER

Patient Registration

Patient's Name: Date of Birth:

Home address:

City: State: Zip:

Home Phone. # Cell Phone. #

Your Employer Work Phone. #

Soc. Security #: E-mail address:

Marital status: Single Married Widow Separated

Are you a full time student?

If patient is a minor, we need: Mother's DOB: Father's DOB:

Responsible Party Name:

Relationship: Spouse's/Parents: Soc Security #

Driver's License #: Spouse's/Parent's Phone #:

Emergency Contact name, address and telephone of a relative not living with you:

How did you hear about our office?

Dental Insurance information (Primary)	If you have secondary insurance
Insured's Name:	Insured's Name:
Insured's Employer:	Insured's Employer:
Insurance Company:	Insurance Company:
Phone #:	Phone #:
DOB:	DOB:
SS#:	SS#:
Group #:	Group #:
ID number#:	ID number#:

Patient's Signature (Parent if a minor) Date

Child's Information

Child's Name: _____ Date of Birth: _____

Child's Primary Care Doctor: _____

Prescription Medications: _____

Herbs/Home Remedies: _____

Allergies: _____

Pregnancy and Birth

Where was your child born: _____

Please indicate any medical problems during birth: _____

Delivery by: Vaginal Birth Caesarean If Caesarean, why?

How many hours did labor last? _____

If premature, how many weeks early? _____

Child's Surgical History

Please describe any previous surgeries: _____

Child's Medical History

Do you have conditions related to any of these symtoms? If so please explain below

	Yes	No		Yes	No
Lung	◯	◯	Brain/Nervous System	◯	◯
Heart	◯	◯	Genital	◯	◯
Kidney/Urinary	◯	◯	Ear/Nose/Throat/Eye	◯	◯
Bone/Muscles	◯	◯	Development Concerns or learning p	◯	◯
Gastro-intestinal	◯	◯	Behavioral Problems	◯	◯
Eating Disorders	◯	◯			

If "Yes" please explains: _____

Are there any other medical conditions or concerns: _____

Mother's Information

Breastfeeding

Are you exclusively breastfeeding? _____

How long are your nursing sessions? _____

How often do you need to nurse? _____

How is your supply? _____

Are you supplementing? _____

If so, what are you using with? _____

Parent signature _____ Date _____ Dentist Signature _____

Integrative Dental OF DENVER

Frenotomy & Frenectomy

Name: _____ Date: _____

Referring Physician: _____ Date of Birth: _____

Name of Parents: _____

Are you seeing a chiropractor/osteopath/occupational therapist/cranial sacred therapist? Who?

_____

Lactation Consultant: _____

Past Medical History:

Birth Weight (lb. /oz.): _____ Present Weight: _____

Family History of Tongue Tie or Lip Tie: _____

Has your baby:	**Yes**	**No**
Received Vitamin K injections	○	○
Born premature	○	○
If yes, Gestation age _____		
Heart disease - If yes, _____	○	○
Any surgery - If yes, _____	○	○
Prior surgery to correct tongue or lip tie	○	○
If yes, when/by whom _____		
Breathe with their mouth open, even a little	○	○
Make noises when breathing	○	○
Weight loss/gain	○	○
Nasal obstruction	○	○
Swallowing issues	○	○
Cyanosis (turning blue)	○	○
Breathing issues	○	○
Reflux/vomiting/spitting up	○	○
Bleeding Problems	○	○

Mother's Symptoms:	**Yes**	**No**
Creased, flattened or blanched nipples after nursing	○	○
Cracked, bruised or blistered nipples	○	○
Bleeding nipples	○	○
Severe pain when your infant attempts to latch: ___/10 (Scale of 0-10)	○	○
Poor or incomplete breast drainage	○	○
Infected nipples or breasts	○	○
Plugged ducts	○	○
Mastitis or nipple thrush	○	○

Baby's Symptoms	**Yes**	**No**
Poor latch	○	○
Falls asleep while attempting to nurse	○	○
Slides off the nipple when attempting to latch	○	○
Colic symptoms	○	○
Reflux symptoms/spit up	○	○
Poor weight gain	○	○
Gumming or chewing of your nipple while nursing	○	○
Unable to hold a pacifier in their mouth	○	○
Short sleep episodes requiring feeding every 2-3 hours	○	○
Choking/gagging	○	○
Fussy/colic	○	○
Clicking	○	○
Painful gas	○	○
Pops off/on	○	○
Shallow latch	○	○
Leaks from corner of mouth	○	○

Patient signature (Parent if child) **Date** **Dentist Signature**

Financial Policy

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

Regarding Payment

Payment for services is due at the time services are rendered unless prior arrangements have been made with the doctor and the billing receptionist.

If dentures, partial dentures, crown and bridge are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented or inserted.

The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date or previous arrangements have been made with the doctor and billing receptionist.
Checks that are returned to our office from your financial institution are subject to a $20.00 returned check fee. This fee covers the processing fees that are charged to our office.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Your **estimated** co-payment for treatment, which is the amount not covered by your insurance, is due at the time service is provided. Your co-payment may be adjusted after the time of service depending upon the final reconciliation of insurance payments. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available through CareCredit upon request and approval.

You will have to take responsibility for any fees your insurance has not covered after 60 days. Any expenses incurred in collecting a past due account will be turned over to a collection agency after 90 days which can include attorney fees.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party: _____ Date: _____

IntegrativeDental
OF DENVER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

You May Refuse to Sign This Acknowledgement

I, _____ have read or received a copy of this office's Notice of Privacy Practices. (Copy is in black book on the table in our waiting area or on our website under "Forms")

_____
{Please Print Name}

_____ _____
{Signature} Guardian Signature

_____
{Date}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself. By signing this, you also allow us to release information to any referring doctor or specialist.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ {Please Print Name}	_____ Relationship
_____ {Please Print Name}	_____ Relationship
_____ {Please Print Name}	_____ Relationship

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ○ Individual refused to sign
- ○ Communications barriers prohibited obtaining the acknowledgement
- ○ An emergency situation prevented us from obtainingacknowledgement
- ○ Other (Please Specify)

Consent for Frenectomy

Diagnosis:

After a thorough oral examination, I have been advised that the reduction of a 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, it has been recommended that a frenectomy be performed at the selected site(s). A soft 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 2-3 week follow up on the proposed care. Photos may be taken, but not of the face 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. Also, an alterative to a frenectomy by my dentist is to seek the care of another health care professional, including but not limited to; 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 his ability.

I CERTIFY THAT I HAVE READ AND FULLY UNDER STAND THIS DOCUMENT AND ALL MY QUESTIONS WERE ANSWERED

Print patient name _____

Date (signature of parent, guardian, or patient)

_____

Date (signature of witness)

_____

Frenectomy

THERE ARE TWO IMPORTANT CONCEPTS TO UNDERSTAND ABOUT ORAL WOUNDS:

1. Any open oral wound likes to contract towards the center of that wound as it is healing (hence the need to keep it dilated open).
2. If you have two raw surfaces in the mouth in close proximity, they will reattach.

I feel that post-procedure stretches are key to getting an optimal result. These stretches are NOT meant to be forceful or prolonged. It's best to be quick and precise with your movements. I feel that getting an affordable LED headlight (like a camping headlight) allows you to get the best results.

You may use Tylenol, Ibuprofen (if 6 months of age or older), arnicapellets (not the cream), Rescue Remedy or other measures to help with pain control. I recommend the purchase of coconut oil. This oil will be used during your stretching exercises. Tylenol dosage: 1.25mL every 6 hours with a maximum of 5mL every 24 hours for a 7-12 lb infant. You can also place frozen breast milk chips under the revision sites or take a warm bath with your little one. Place 1 arnica pellet in your child's mouth every 30-90 minutes as needed for pain.

The main risk of a frenotomy is that the mouth heals so quickly that it may prematurely reattach at either the tongue site or the lip site, causing a new limitation in mobility and the persistence or return of symptoms. The exercises demonstrated below are best done with the baby placed in your lap (or lying on a bed) with the feet going away from you.

STRETCHES

A SMALL AMOUNT OF SPOTTING OR BLEEDING IS COMMON AFTER THE PROCEDURE, ESPECIALLY IN THE FIRST FEW DAYS. BECAUSE A LASER IS BEING USED, BLEEDING IS MINIMIZED. WASH YOUR HANDS WELL PRIOR TO YOUR STRETCHES (GLOVES AREN'T NECESSARY). APPLY A SMALL AMOUNT OF COCONUT OIL TO YOUR FINGER PRIOR TO YOUR STRETCHES. MY RECOMMENDATION IS THAT STRETCHES BE DONE 3X/DAY FOR 4 WEEKS. **Link to video for frenectomy aftercare stretches: http://yourcoloradodentist.com/videos/**

The Upper Lip is the easier of the 2 sites to stretch. If you must stretch both sites, I recommend that you start with the tongue. For the upper lip, simply place your finger under the lip and move it up as high as it will go (until it bumps into resistance). Then gently sweep from side to side 5 times. Remember, the main goal of this procedure is to insert your finger between the raw, opposing surfaces of the lip and the gum so they can't stick together.

The Tongue should be your first area to stretch. Insert both index fingers into the mouth (insert one in the mouth and go towards the cheek to stretch out the mouth, making room for your other index finger). Then use both index fingers to dive under the tongue and pick it up, towards the roof of baby's mouth.

1. Once you are under the tongue, push deep under the tongue to get behind the diamond. Try to lift the tongue up as high as it will go (towards the roof of the baby's mouth). With one finger propping up the tongue, place your other finger in the middle of the diamond and turn your finger sideways and use a roller pin motion from front to back to try and keep the diamond as deep as possible. Make sure your finger starts within the diamond when doing this stretch
2. With your fingers still in your little one's mouth, push both fingers under the diamond as though you were pushing towards their chin and then stroke along the sides of the diamond pulling the tongue long and tall. This stretch requires more effort and you should see the tongue lift up.

SUCKING EXERCISES

It's important to remember that you need to show your child that not everything that you are going to do to the mouth is associated with pain. Additionally, babies can have disorganized or weak sucking patterns that can benefit from exercises. The following exercises are simple and can be done to improve suck quality.

1. Slowly rub the lower gumline from side to side and your baby's tongue will follow your finger. This will help strengthen the lateral movements of the tongue.
2. Let your child suck on your finger and do a tug-of-war, slowly trying to pull your finger out while they try to suck it back in. This strengthens the tongue itself.
3. Let your child suck your finger and apply gentle pressure to the palate, and then roll your finger over and gently press down on the tongue and stroke the middle of the tongue.

STARTING SEVERAL DAYS AFTER THE PROCEDURE, THE WOUND(S) WILL LOOK WHITE AND/OR YELLOW AND WILL LOOK VERY SIMILAR TO PUS.

This is a completely normal inflammatory response. Do not let your child's regular doctor, lactation consultant, friend who thinks they're an expert, or anyone else make the determination for you. If you think an infection exists, give our office a call.

IT IS ESSENTIAL THAT YOU FOLLOW-UP WITH YOUR LACTATION CONSULTANT AFTER THE PROCEDURE TO ENSURE OPTIMAL RESULTS. CALL OUR OFFICE FOR ANY OF THE FOLLOWING:

- Uncontrolled bleeding
- Refusal to nurse or take a bottle
- Fever > 101.5

Dr. Bieneman's cell phone: 574-807-2083