FRENECTOMY PATIENT REGISTRATION AND INFORMATION

Patient Information

Today's Date_____ Patient Name _____

Parent/Guardian Names _____

Birth Date_____ Age_____ Sex M F

Address_____City_____State_____Zip_____

Email_____ Cell Phone_____

Have we seen a member of your family before? Y N Reason for today's visit_____

Emergency Contact Name & Phone Number_____

Whom may we thank for referring you?_____

Insurance Information

Who is responsible for this account? _____ Relationship to Patient_____

Dental Primary Insurance Co._____Subscriber's Name_____

Birthdate_____ SSN_____ ID#_____ Group#_____

Is patient covered by additional insurance? Y N

Dental Secondary Insurance Co._____ Subscriber's Name_____

Birthdate_____ SSN_____ID#_____Group#_____

Insurance Policy

All frenectomy patients pay for services today. We may be able to send an insurance claim for you, but full payment is due at time of service. You are responsible to follow up with your insurance company to verify they received & processed a claim. If your insurance pays anything, you will receive payment directly from your insurance company. We are happy to help in any way possible to get payment for services, however there is no guarantee what or if insurance will pay anything. Please sign acknowledging that any and all insurance billing questions have been asked and answered & you understand our insurance policy! Thank you.

_____ _____

Signature of Insured Parent/Guardian Date

The information on this form is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance. I will not hold my dentist or any member the staff responsible for any errors or omissions that I may have made in the completion of this form. I give permission to take before & after pictures of the surgery site. These pictures are used for documentation of the surgery and kept with your chart. If your insurance company request before and after pictures, we will send them.

_____ _____

Signature Date

FRENECTOMY CONSENT

The purpose of this procedure at a young age is to allow the baby to latch properly during breastfeeding and reduce maternal discomfort. For older children/adults the purpose is to gain and maintain good oral health, allow for more normal growth, allow for correct speech development, and to reduce any future problems associated with tongue and/or lip-ties.

During treatment, it may be necessary for your child to be restrained by you and the office staff to control undesirable movements. Dr. Jesse will use a small amount of topical anesthetic and local anesthetic to numb the area so your child will be comfortable during the procedure. The procedure is generally quick and there is very minimal bleeding. The laser cauterizes as it trims away the muscle fibers causing little bleeding and resulting in a scar free wound that will heal in one to two weeks.

Dr. Jesse anticipates great results; however, there are no guarantees as to how much benefit will be achieved after the procedure. 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.

Some parents say that their child was fussy the first night but had no complications. You may choose to give your child children's pain medication, but it is usually not necessary for most patients. After completing this type of surgery on thousands of infants. Dr. Jesse has not experienced any significant problems that would indicate any serious risks of the surgery.

Not treating your child's existing dental problem may result in the following but not limited to: continued breastfeeding problems, complications with bone growth and tooth eruption, tooth decay, and complications with future orthodontic treatment. Parents and guardians should understand recommended procedures, alternative options and anticipated results.

All surgery is completed using appropriate laser technology, which has proven safe for infants as well as all patients.

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. I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness, swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I have been given the opportunity to ask Dr. Jesse and his staff 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. By signing this consent, I indicate that I have the legal authority to grant this permission. I certify that I read and write English and have read and fully understand this consent. I also agree to pay all fees and have given Dr. Jesse a complete medical history of my child.

_____ _____ _____ _____

Guardian Name Signature Patient Name Date