MEDICAL HISTORY

Patient's name_____Male_____Female_____

Birth date_____

Address_____

Mother's phone: Home_____ Cell_____

Email_____

Referred by_____

Reason for visit: Tongue tie_____ Lip tie_____ Consult _____

Parents: Mother's name (print)_____ Date of birth_____

Father's name(print)_____ Date of birth_____

Please list any allergies/medical conditions_____

INSURANCE INFORMATION

DENTAL INSURANCE:
Insurance company name_____
Policy holder name_____Date of Birth_____
Policy holder's employer (if employer sponsored)_____
Group #_____ ID/Member # (if none, SS#)_____

MEDICAL INSURANCE
Insurance company name_____
Policy holder name_____Date of Birth_____
Policy holder's employer (if employer sponsored)_____
Group #_____ID/Member # (if none, SS#)_____

Person responsible for payment (print)_____
Signature of parent or guardian_____

VOLLER DENTISTRY, PC
General - Cosmetic - Orthodontic

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. Voller 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. Voller 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.

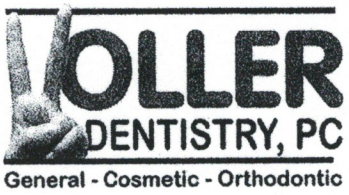
Acknowledgment of Informed Consent

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. Voller 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 have given Dr. Voller a complete medical history of my child.

Child_____
(Print Child's Name)

Parent_____
(Parent's or Guardian's Signature)

Today's Date_____



Infant Questionnaire

Patient Name:_____ Birth Date:_____ Today's Date:_____

Birth Weight: _____ Present Weight:_____

Address:_____ City:_____ State:_____ Zip:_____

Referred by:_____ Phone: _____

Pediatrician:_____ Phone: _____

Lactation Consultant:_____ Phone: _____

Medical History: Has child experienced any of the following?

1. Was your infant premature? YES NO
2. Has your infant had any surgery? YES NO
3. Is your infant taking any medication? YES NO

4. Has your infant experienced any of the following?

_____ Poor latch
_____ Falls asleep while attempting to latch
_____ Slides or clicks off the nipple when attempting to latch
_____ Colic or Reflux Symptoms
_____ Seems frustrated while attempting to feed
_____ Poor weight gain
_____ Gumming or chewing of nipple when nursing
_____ Dribbles milk out of sides of mouth while nursing
_____ Unable to flare upper lip while feeding
_____ Short sleep episodes requiring feedings every 2-3 hours

5. Do you have any of the following signs or 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 breasts
_____ Plugged milk ducts
_____ Mastitis or nipple thrush

ADDITIONAL COMMENTS OR CONCERNS