PATIENT INFORMATION

(Please Print)

Name ________________________________ Birthdate _____-_____-______

Preferred Name____________________ Marital Status_____________

Home Address__________________________________ Apt #_________

City______________________________ State__________ Zip_________

Please circle: Male Female

Who can we thank for referring you to our office?___________________________________

GENERAL INFORMATION (Parents)

- (Mr.) Name____________________________________ Phone:__________________
  Home Address____________________________________ Apt#__________
  City __________________ State___________ Zip____________ Marital Status______
  Social Security Number__________________________ DOB____________
  Occupation______________________ Employer __________________
  Email Address____

- (Mrs., Miss., Ms.) Name______________________________ Phone:________________
  Home Address__________________________________ Apt #_____________
  City__________________ State____________ Zip____________ Marital Status______
  Social Security Number____________________ DOB________________
  Occupation______________________ Employer__________________
  Email Address ____

- Insurance Co.______________________________ Policy Holder:_________________
  Insurance Address______________________________ Phone:__________________
  Employee ID #____________________________ Group #____________________

- Secondary Insurance Co.___________________________ Policy Holder:____________
  Insurance Address____________________________________ Phone:________________
  Employee ID #____________________________ Group #____________________

I understand that the information that I have given today is correct to the best of my knowledge. I understand that this information will be hold in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform, with my informed consent, any necessary dental services that I may need during diagnosis and treatment. Payment is due in full at time of service.

Signature:____ Date:____________________

INFANT HISTORY

Patients Name:____________________ DOB:_________________ Today's Date:___________________

Male_____ Female_____ Birth Weight:________ Present Weight:________ Birth Hospital:___________________

Vaginal Birth_________ C-Section_________ Any birth complications?:___________________________________

Are you presently breastfeeding? Yes ______ No______ If not, how long since you stopped?_________________

Medical History:

1. Infants are usually given Vitamin K at birth to prevent bleeding in the first 8 weeks of life. Did your child receive the Vitamin K shot? Yes ______ No _______
2. Was your infant premature? YES______ NO_______ If Yes, how many weeks?_______________
3. Does your infant have any heart disease? YES ______ NO_______
4. Does your infant have any bleeding disorders? YES________ NO_______
5. Any other medical problems the doctor should be aware of? YES________ NO_______ If yes, explain________________________
6. Has your infant had any surgery? YES_______ NO______ If yes, explain____
7. Has your infant experienced any of the following? Please check/circle/elaborate as needed.

___ Shallow latch at breast or bottle
___ Falls asleep while eating
___ Slides or pops on and off the nipple
___ Colic problems/cries a lot
___ Reflux symptoms
___ Clicking or smacking noises when eating
___ Spits up often? Amount/Frequency______________
___ Gaggling, Choking, coughing when eating
___ Poor weight gain
___ Hiccups often
___ Lip curls under when nursing or taking bottle

___ Gumming or chewing nipple while nursing
___ Pacifier falls out easily, doesn't like, won't stay in
___ Milk dribbles out of mouth when nursing/bottle
___ Short sleeping requiring frequent feedings every 1-2 hrs
___ Snoring, noise breathing, or mouth breathing
___ Feels like a full time job just to feed baby
___ Nose congested often
___ Baby is frustrated at the breast or bottle
___ Moves head side to side when latching
How often does baby eat?_________________________________
How long does baby take to eat?______________________________

8. Is your infant taking any medications? _______ Reflux _______ Thrush Name of Medication:___________________________
9. Has your infant had a prior surgery/procedure to correct the tongue or lip tie? If yes- When, Where, by Whom?
   ____
10. Have you or have you had any of the following signs or symptoms? Please check/circle/elaborate as needed.

___ Creased, flattened, or blanched nipples
___ Lipstick shaped nipples
___ Blistered or cut nipples
___ Bleeding nipples
Pain on scale of 1-10 when first latching:_______________
Pain on scale of 1-10 during nursing:__________________

___ Poor or incomplete breast drainage
___ Infected nipples or breasts
___ Plugged ducts/engorgement/mastitis
___ Nipple thrush
___ Using a nipple shield
___ Baby prefers one side over other _____R ______L

Pediatrician/Family Physician _________________________ Phone: ____________________________
Lactation Consultant:________________________________Phone: ____________________________
Other Therapist:____________________________________ Phone:____________________________
Who referred you to us?____________________________ Phone:______________________________

______________________________________DOCTORS USE ONLY____

Exam: Palate __________ Gum Ridges: ____________ Lips: Type __________ Face______________________________
Tongue: Type ____ Coated____ Cupping _____ Lateralization_____ Lift____ Extension____ Spread_____ Vacuum_____
Treatment: Scissors______ Laser______ Settings:____ Safety glasses worn______
Anesthetic_____Tropical___________ Local_____________
Post Op Instructions:____

Ped Z Dental
Dr. Stacey Zaikoski, DDS

HIPAA PATIENT ACKNOWLEDGEMENT NOTICE OF PRIVACY PRACTICES, CONSENT, AUTHORIZATION AND RECORDS RELEASE FORM

You may refuse to sign this acknowledgment & authorization. In refusing we may not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices WHICH CAN BE FOUND IN a HARD BOUND BOOK IN OUR RECEPTION/WAITING ROOM for this healthcare facility. A copy of this signed dated document shall be effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI (protected health information) DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OF RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR OR FACILITIES IN THE FUTURE.**

____
Please **PRINT** name of PATIENT (s)

____
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____
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____
Please **PRINT** name of PATIENT (s)

____
PRINT name Parent/Guardian

____
Relationship to patient(s)

Please list any other parties who can have access to your health information: (this includes step-parents, grandparents and caretakers who can have access to patient's records)

Name: ____________________ Relationship: ____________________

Name: ____________________ Relationship: ____________________

I AUTHORIZE CORRESPONDENCE FROM THIS OFFICE TO CONFIRM MY CHILD/CHILDREN(S) APPOINTMENTS, TREATMENT/HEALTH INFORMATION, AND BILLING INFORMATION, VIA:

Cell Phone Confirmation
Home Phone Confirmation
Work Phone Confirmation

Text Message - Cell Phone
Mail
Email Confirmation

____
Signature of patient or parent/guardian

____
Date

Ped Z Dental
Dr. Stacey Zaikoski, DDS

Financial Policy

Thank you for choosing us as your dental provider. We are committed to your successful treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to your treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, VISA, MASTERCARD AND CARE CREDIT.

Insurance

We require all deductibles and co-pays be paid at the time of service. **The balance is your responsibility regardless of whether or not your insurance company pays for your claim**. We must have the correct insurance information in order for us to bill your insurance company. We are a 3rd party to the contract. **We file claims to your insurance as a courtesy to you. It's ultimately your responsibility to know and understand your dental insurance. IE: Coverages, Maximums and Frequencies; including deductibles**. If your insurance company has not paid your account within 60 days, the balance becomes your responsibility. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary by your insurance company.

Usual and Customary Rates

Our practice is committed to providing the best possible care to our patients. Our fees are based on what is usual and customary for our area. You are responsible for payment regardless on insurance company's arbitrary determination of usual and customary rates.

Unique Family Situations

We will be happy to submit to either parent's insurance, however, **it is our office policy that the parent who brings the child in for their appointment is responsible for any co-pays and the balance on the account.**

Missed Appointments

We may apply a missed appointment fee for any missed appointments. We have set that time aside to serve our patients dental needs. We ask you respect that time by keeping scheduled appointments.

Waver of Confidentiality

You understand that if this account is submitted to an attorney or collection agency, if taken to court, or if your past due status is reported to a credit reporting agency, your treatment at our office may become a matter of public record.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS.

I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY:

X______________________________________ **Date** ______________________

Ped Z Dental
Dr. Stacey Zaikoski, DDS

DIGITAL MEDIA CONSENT

I/we, ______________________________, the parent(s)/guardian(s) of (child's full name) ______________________________, hereby give Dr. Greg Notestine, DDS permission to use any still and/or moving images, including video footage, photographs, and audio footage depicting my/our child named above for the following uses:

-Advertisements, marketing, leaflets, or any other use such as training, educational, or publicity purposes

Signed:______________________________ Date:____________________

Signed:______________________________ Date:____________________

INFORMED CONSENT

The **lingual frenectomy/frenotomy** is a minor surgical procedure that involves clipping and/or lasering the band of tissue located on the underside of the tongue (frenum or frenulum). When this band is too tight, too short, or both, normal tongue movement is prevented.

The treatment may accomplish the following, but not be limited to:

- Allow the tongue to move in a greater range of motion
- Possibly improve breastfeeding comfort
- Possibly improve breastfeeding efficiency
- Possibly reduce the severity of speech difficulties

Complications of this treatment may include, but not be limited to:

- Excessive bleeding
- Damage to the vital structures under the tongue
- No perceivable benefit may be achieved

The **labial frenectomy/frenotomy** is a minor surgical procedure to free the lip attachment from the gums when it is too tight and/or too short. It can restrict proper lip movement and flexibility.

The treatment may accomplish the following, but not be limited to:

- Allow adequate lip flange to improve nursing effectiveness
- Reduce the pockets on either side of the frenum to prevent food trapping
- Give the upper lip more freedom of movement for speech sounds
- Possible reduction in reflux/aerophagia

Complications of this treatment may include, but not be limited to:

- Excessive bleeding
- Lip muscle damage
- No perceivable benefit may be achieved

Please note that this treatment is NOT intended to prevent a gap between the upper front teeth. If that is the goal, it may need treatment at about 11-12 years of age.

______ I accept treatment ______ I decline treatment Signed:______________________________ Date: ____________________

Witness:______________________________ Date:____________________

I give Dr. Notestine, DDS permission to contact and share any information regarding treatment and/or medical history with my medical provider:

Provider Name: ______________________________ Contact Phone:______________________________

Provider Name: ______________________________ Contact Phone:______________________________