FLORIDA TONGUE TIE INSTITUTE

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Board Certified Pediatric Dentist

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www.floridatongue.com

Patient Information

Patient:_____Today's Date:_____

Preferred Name: _____Date of Birth: _____Sex: M / F (Gender Identity: M / F)

Home Address:_____City:_____Zip:_____

May we text message appointment confirmation? If so, which cell phone number?_____

Email address:_____

How did you hear about practice?_____

If patient is 18 years old or over, please fill in the following, if not, parent/guardian fill in next section.

Employer:_____Occupation:_____

Driver's License #:_____ Social Security Number:_____

Cell Phone #:_____Home Phone #:_____Work Phone #:_____

Parent/Guardian Information if Patient is a Minor

Parent 1 Information - Relationship to patient: ☐ Mother ☐ Father ☐ Grandparents ☐ Other:_____

Name:_____Date of Birth:_____

Employer:_____Occupation:_____

Driver's License #:_____ Social Security Number:_____

Cell Phone #:_____Home Phone #:_____Work Phone #:_____

Home Address:_____City:_____Zip:_____

Parent 2 Information - Relationship to patient: ☐ Mother ☐ Father ☐ Grandparents ☐ Other:_____

Name:_____Date of Birth:_____

Employer:_____Occupation:_____

Driver's License #:_____ Social Security Number:_____

Cell Phone #:_____Home Phone #:_____Work Phone #:_____

Home Address:_____City:_____Zip:_____

Financial Policy

Person Financially Responsible for Account

Name:_____Relationship to Patient:_____

Billing Address:_____City:_____Zip:_____

Cell Phone #:_____Home Phone #:_____Work Phone #:_____

Payment is due in full *at the time service is provided. We will provide a medical health insurance form with all necessary codes so you can file directly to your health insurance provider for possible reimbursement. We cannot guarantee percent of reimbursement, but we are happy to supply you directly with letters of medical necessity, detailed statements, narratives, or any other information that may help assist your claim. By signing, you agree that you are responsible for submitting medical and/or dental claims for reimbursement.*

Print Name (Patient/Guardian): _____

Signature:_____ Date: _____

Patient Medical Questionnaire

Primary Care Physician :_____Phone #:_____

Lactation/Feeding Therapist : _____ Phone #: _____

Speech/Other Therapist: _____ Phone #: _____

List all current medications the patient is taking (prescription & over the counter), including the reason for taking the medication: _____

_____

Please list any known allergies:_____

Y N Acid Reflux	Y N Cancer/Tumor/Malignancy	Y N Heart Murmur	Y N Seizure/Epilepsy
Y N ADHD/ADD/Hyperactivity	Y N Cerebral Palsy	Y N Hepatitis	Y N Sensory Issues
Y N Allergies	Y N Chemotherapy/Radiation	Y N HIV/AIDS	Y N Sickle Cell Disease
Y N Anemia	Y N Cleft Lip/Palate	Y N Kidney Disease	Y N Sinus Problems
Y N Arthritis	Y N Developmental Delay	Y N Latex Sensitivity/Allergy	Y N Sleep Apnea/Snoring
Y N Asthma	Y N Down Syndrome	Y N Liver Disorder	Y N Speech Delays
Y N Autism/Spectrum Disorder	Y N Diabetes	Y N Premature Birth	Y N Transplant
Y N Birth Defects	Y N GI/Stomach Disease	Y N Profound Mental Impairment	Y N Tuberculosis
Y N Bleeding Problems	Y N Hearing Impairment	Y N Psychologic/Nervous Disorder	Y N Vision Problems
Y N Breathing Problems	Y N Heart Condition/Disorder	Y N Rheumatic Fever	Y N Other

If other, please specify:_____

Please provide more information on any of the above marked yes:_____

Appointment Policy

We reserve your appointment time specifically for you! If you need to reschedule, please give us at least 48 hours notice so that we may give someone else the opportunity to use that time. A fee, up to $75, may be charged for late cancellations (less than 48 hour notice) and/or missed appointments. This fee must be paid before a new appointment is scheduled. After three broken appointments within one year's time, we unfortunately will need to assist you in transferring the patient's records to another provider.

Print Name:_____ Signature:_____ Date: _____

HIPAA
Consent for Use and Disclosure of Protected Health Information (PHI)

I, _____, the undersigned, and _____
(print name of Parent, Legal Guardian or Patient if 18) (Relationship to the Patient)

of the above named patient, herby authorize Florida Tongue Tie Institute (hereafter collectively referred to as the "Practice") to use and disclose the entire medical record concerning the above named patient (hereafter referred to as the "Patient") in accordance with the attached Notice of Privacy Practices (NOPP). I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be effective as the original. I release, hold harmless and agree to indemnify Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize the Practice to use and disclose verbally, by mail, fax or unencrypted e-mail, the Patient's medical record.

Print Name:_____ Signature:_____ Date: _____

Acknowledgement

The information provided in this form is compete to the best of my knowledge. I will notify Florida Tongue Tie Institute at future visits if any of the information changes.

Print Name: _____ Relationship: _____

Signature: _____ Date: _____