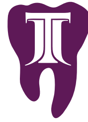


JAMES T. JESSE, D.D.S.
TOTAL FACIAL ESTHETICS

# FRENECTOMY PATIENT REGISTRATION AND HISTORY

## PATIENT INFORMATION

PATIENT FIRST NAME ____________________

PATIENT LAST NAME ____________________

MIDDLE INITALS __________ DATE __________

ADDRESS ____________________

CITY __________ STATE ______ ZIP ______

E-MAIL ____________________

HOME PHONE __________ CELL PHONE __________

BIRTHDAY __________ AGE ______ SEX ______

PARENT / GUARDIAN NAMES ____________________

IN CASE OF EMERGENCY, CONTRACT ____________________

PHONE ____________________

WHOM MAY WE THANK FOR REFERRING YOU? ____________________

## INSURANCE INFORMATION

WHO IS RESPONSIBLE FOR THIS ACCOUNT? ____________________

RELATIONSHIP TO PATIENT ____________________

☐ MEDICAL INSURANCE ☐ DENTAL INSURANCE

INSURANCE CO. ____________________

ID # __________ GROUP # __________

SUBSCRIBER'S NAME ____________________

BIRTHDAY __________ SSN __________

IS PATIENT COVERED BY ADDITIONAL INSURANCE? ☐ YES ☐ NO

SECONDARY INSURANCE CO. ____________________

ID # ____________________

SUBSCRIBER'S NAME ____________________

BIRTHDAY __________ SSN __________

## REASON FOR TODAY'S VISIT

## FINANCIAL AGREEMENT

I ACKNOWLEDGE THAT PAYMENT IS DUE AT THE TIME OF TREATMENT, UNLESS OTHER ARRANGEMENTS ARE MADE. I AGREE THAT PARENTS/GUARDIANS ARE RESPONSIBLE FOR ALL FEES AND SERVICES RENDERED FOR TREATMENT OF A MINOR/CHILD. I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL CHARGES NOT COVERED BY INSURANCE.

__________ ____________________

DATE SIGNATURE OF INSURED / GUARDIAN

## ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED, HAVE INSURANCE WITH

____________________

NAME OF INSURANCE COMPANY(IES)

AND ASSIGN DIRECTLY TO DR. JESSE ALL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS WHETHER MANUAL OR ELECTRONIC.

__________ ____________________

DATE SIGNATURE

## MINOR / CHILD CONSENT

I, BEING THE PARENT OR GUARDIAN OF

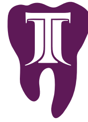
____________________

NAME OF MINOR / CHILD

DO HEREBY REQUEST AND AUTHORIZE THE DENTAL STAFF TO PERFORM NECESSARY DENTAL SERVICES FOR MY CHILD, INCLUDING BUT NOT LIMITED TO X-RAYS AND ADMINISTRATION OF ANESTHETICS WHICH ARE DEEMED ADVISABLE BY THE DOCTOR, WHETHER OR NOT I AM PRESENT AT THE ACTUAL APPOINTMENT WHEN THE TREATMENT IS RENDERED.

__________ ____________________

DATE SIGNATURE OF INSURED / GUARDIAN



JAMES T. JESSE, D.D.S.
TOTAL FACIAL ESTHETICS

# FRENECTOMY PATIENT REGISTRATION AND HISTORY (CONTINUED)

## HEALTH HISTORY

PHYSICIAN'S NAME ______________________ DATE OF LAST VISIT ______________________

LIST ANY MEDICATIONS ______________________

WAS A VITAMIN K SHOT GIVEN AT BIRTH (TO THE BABY)? ☐ YES ☐ NO ☐ I DON'T KNOW

ALLERGIES: ☐ NONE KNOWN ☐ LOCAL ANESTHETIC ☐ LATEX ☐ SHELLFISH ☐ PENICILLIN ☐ OTHER

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR MEDICAL HISTORY? ______________________

______________________

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 FOR BENEFITS FOR WHICH I AM ENTITLED. I WILL NOT HOLD MY DENTIST OR ANY MEMBER OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

| ______________________ | ______________________ |
|---|---|
| DATE | SIGNATURE |

## 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. MOST 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 OVER 2000 INFANTS, THIS OFFICE 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 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 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 DEPEND ON PARENTS FOLLOWING ALL POSTOPERATIVE RECOMMENDATIONS FOR KEEPING THE SURGICAL SITES FROM HEALING TOGETHER.

### 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.

| __________ | ______________________ | ______________ | ______________________ |
|---|---|---|---|
| DATE | SIGNATURE OF PARENT / GUARDIAN | PRINT NAME | RELATIONSHIP TO PATIENT |