Patient's Name:_____ Patient's DOB:_____ Patient's age:_____ Sex:____

Today's Date:_____ Parent's Name(s): _____

Primary Phone:_____ Email:_____

Address:_____ City, State:_____ Zip:_____

Insurance Subscriber DOB:_____ Insurance Subscriber ID:_____ Insurance Subscriber SSN: _____

Pediatrician's Name:_____

Are you currently working with a lactation consultant? ❍Yes ❍No

If yes, who and when?_____

Is your child currently being seen for other services? (chiropractic care, physical therapy, occupational therapy, craniosacral therapy, speech therapy, feeding therapy, osteopathy etc.) ❍Yes ❍No If yes, what type? _____

If yes, why and by whom?_____

If yes, when/total number of visits?_____

Do you have any concerns with your child's gross motor development? (rolling, sitting, crawling, etc.) _____

Does your child have a preference for turning or tilting his/her head? (in car seat stroller, while sleeping, etc.)_____

Are you concerned with your baby's head shape? _____

Is this your first child? ❍Yes ❍No Family history of tongue tie? ❍Yes ❍No

Has this Dr. treated you or a family member in the past? ❍Yes ❍No If so, who/when? _____

How did you hear about our office? _____

Please summarize your main concerns/reason for visit: _____

MEDICAL HISTORY

Birth weight (lb/oz):_____ Most current weight (lb/oz):_____

List all current **maternal** medications/supplements:_____

List all current **child** medications/supplements:_____

Does your child have any allergies? (Food, medication, etc.) ❍Yes ❍No If yes, please describe: _____

Did your child receive Vitamin K injections? ❍Yes ❍No Are your child's vaccines up to date? ❍Yes ❍No

Does your child have any heart diseases? ❍Yes ❍No If yes, please describe: _____

Has your child had any surgeries? ❍Yes ❍No If yes, what type(s) and when: _____

Has your child had prior surgery to correct a tongue or lip tie? ❍Yes ❍No

If yes, what type(s) and where: _____

Does your child have any other medical conditions or health concerns? ❍Yes ❍No

If yes, please describe: _____

PREGNANCY/LABOR HISTORY: ❍Normal or ❍High Risk

Birth Location: _____

Was your child premature? ❍Yes ❍No If yes, gestational age at birth: _____

Were there any additional stressors with labor? ❍Yes ❍No

Please select all that apply: ❍Vaginal birth ❍Long labor ❍Unplanned C-section ❍Planned C-section

❍Excessive pushing ❍Trauma from vacuum or forceps ❍Breech birth

Other (please explain): _____

Difficulty with latch after birth? ❍Yes ❍No

MODE OF FEEDING

Please describe your current mode(s) of feeding: _____

Are you currently breastfeeding? ❍Yes ❍No

If yes, please select: ❍Exclusively breastfeeding ❍Mix of breast/bottle feeding

How would you rate your milk supply? ❍Oversupply ❍Good ❍Fair ❍Poor

Do you have a history of breast surgery? ❍Yes ❍No

Are you currently using a nipple shield? ❍Yes ❍No

Are you using an SNS? ❍Yes ❍No

Is this your first time breastfeeding? ❍Yes ❍No ❍ N/A Other breastfed children/how long? _____

Are you currently bottle feeding? ❍Yes ❍No

If yes, what type of bottles? _____

Are you supplementing with pumped breast milk? ❍Yes ❍No How many bottles/ounces per day? _____

Are you supplementing with formula? ❍Yes ❍No How many bottles/ounces per day? _____

Type of formula: _____

Does your baby use a pacifier? ❍Yes ❍No

BABY'S SYMPTOMS

Does your baby CONSISTENTLY fall asleep while attempting to nurse?	❍ Yes	❍ No
Does your baby CONSISTENTLY slide off breast when latching/feeding? (Skip if N/A)	❍ Yes	❍ No
Does his/her upper lip CONSISTENTLY curl inward (does not flip out) when latched?	❍ Yes	❍ No
Does your baby CONSISTENTLY have his/her mouth open at rest?	❍ Yes	❍ No
Does milk or formula leak/spill out of mouth while feeding at breast/bottle?	❍ Yes	❍ No
Does your baby CONSISTENTLY experience colic symptoms?	❍ Yes	❍ No
Does your baby CONSISTENTLY become visibly frustrated at the breast/bottle?	❍ Yes	❍ No
Does your baby CONSISTENTLY exhibit reflux symptoms?	❍ Yes	❍ No
Is your baby CONSISTENTLY extremely gassy?	❍ Yes	❍ No
Does your baby CONSISTENTLY snore during sleep?	❍ Yes	❍ No
Does your baby CONSISTENTLY exhibit noisy/congested breathing?	❍ Yes	❍ No
Has your pediatrician noted slow or poor weight gain?	❍ Yes	❍ No
Have you done any pre- and post- feeding weight checks?		
If so, what was the transfer rate: _____ounces per _____minutes	❍ Yes	❍ No
Does your baby CONSISTENTLY display gumming or chewing of your nipple while nursing?	❍ Yes	❍ No
Is there a CONSISTENT "clicking noise" while feeding?	❍ Yes	❍ No
Does your baby seem CONSISTENTLY dissatisfied after feeding sessions?	❍Yes	❍ No

If not, please explain: _____

What is the average length of feeding time in minutes? ❍Less than 15 ❍15-30 ❍30-45 ❍45-60 ❍60+

CHILD'S SYMPTOMS

Please fill out the following sections only if age-appropriate for your child.

Eating Solid Foods

Does your child…

Show little interest in food?	❍Yes	❍No
Hold food in his/her mouth for extended periods of time?	❍Yes	❍No
Swallow large chunks of partially chewed food?	❍Yes	❍No
Choke on solids or liquids?	❍Yes	❍No
Spit food out?	❍Yes	❍No
Have any digestive issues?	❍Yes	❍No
Spit up or throw up shortly after eating?	❍Yes	❍No

Speaking

Does your child have language or articulation difficulties or delays?	❍ Yes	❍No
If yes, please describe: _____		
Is your child currently seeing a speech pathologist?	❍ Yes	❍No

Sleeping

Does your child…

CONSISTENTLY sleep with an open mouth at night? ❍Yes ❍No

CONSISTENTLY sleep noisily/restlessly? ❍Yes ❍No

CONSISTENTLY sleep with a pacifier? ❍Yes ❍No

Does your child CONSISTENTLY wake up through the night? ❍Yes ❍No

If yes, how many times per night is child waking? _____

If yes, how many nights per week is his/her sleep affected? _____

Please describe your current sleeping arrangement. ❍Co-sleeping ❍ In bassinet/crib

Breathing

Does your child…

CONSISTENTLY rest in an open mouth posture during the day? ❍Yes ❍No

CONSISTENTLY mouth-breathe during the day? ❍Yes ❍No

CONSISTENTLY exhibit a forward head posture? ❍Yes ❍No

Please describe any other disturbances to eating, speaking, sleeping, breathing:

_____

MOTHER'S SYMPTOMS (if breastfeeding)

Please rate your level of discomfort while feeding: ❍None ❍Very Low ❍Low ❍Medium ❍High ❍Very High

Are your nipples becoming creased/flattened/lipstick-shaped/blanched white after nursing? ❍Yes ❍No

If yes, please select: ❍Right Side ❍Left Side ❍Both

Are your nipples becoming cracked, bruised, or blistered after nursing? ❍Yes ❍No

If yes, please select: ❍Right Side ❍Left Side ❍Both

Are your nipples bleeding? ❍Yes ❍No

If yes, please select: ❍Right Side ❍Left Side ❍Both

Is there any severe pain when your baby attempts to latch? ❍Yes ❍No

If yes, please select: ❍Right Side ❍Left Side ❍Both

If yes, please select: ❍Pain subsides after initial latch ❍Pain persists throughout feeding

❍Pain is felt in-between feeds

Are you experiencing poor or incomplete breast drainage? ❍Yes ❍No

Do you have a history of, or currently have, mastitis? ❍Yes ❍No

Do you have a history of, or currently have, nipple/baby oral thrush? ❍Yes ❍No

CONCERNS & GOALS

In a sentence or two, please share your current feeding concerns:

_____

_____

In a sentence or two, please share your feeding goals:

_____

_____

Medical Information Release Form (HIPAA Release Form)

NAME:_____ DATE OF BIRTH: _____

Release of information

[ ] **I hereby authorize** Dr. Handa and affiliates to release my child's health/treatment records to the individuals below.
*We typically release appointment reports to the providers listed.

Parent/Spouse/ Relative _____

Referring Provider _____

Pediatrician _____

Lactation Consultant _____

Speech/Physical/Occupational Therapist _____

Bodyworker/Doula/Midwife/Other _____

(DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY)

[ ] **I do not authorize** Ratti Handa, D.M.D or affiliates to release any medical information.

This ***Release of Information will remain in effect until terminated by me in writing.***

Messages

Please call [ ] My Home [ ] My work [ ] My Cell # _____

If unable to reach me:

[ ] You may leave a detailed message

[ ] Please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day)_____ between (time) _____

Signed:_____Date: _____

Witness:_____Date: _____

Treatment Fee Schedule:
Fee-for-Service Payment Plan and Maximum Out-of-Pocket Costs

Pt:_____

Dear Patients and Parents,

Thank you for choosing our practice for your healthcare needs. We greatly appreciate your trust and confidence in our expertise and consider it an honor and privilege to help you and your family.

We chose to build a patient-centered model for our practice that does not allow insurance companies to dictate the care we provide. This means that we are not contracted with insurance carriers. Because of this, we collect payment directly from the patient during the time of your visit.

Our office does, however, provide concierge billing services and will work directly with your insurance company to file for any out of network benefits your insurance company offers, so that your insurance company may reimburse you directly according to the terms of your policy.

Our consultation, procedure, and follow-up service fees are in accordance with the following schedule. Because most insurance companies provide reimbursement based on a fee-for-service payment plan, you may notice some variance between the amount billed to your insurance company and the fees we collect from you as a patient or parent.

Because we desire to keep our service affordable and understand the increasing burden of healthcare expenses, our policy is to cap the maximum costs to our families at $850 per patient. In some cases, if additional services are rendered, we aim to provide these services as a courtesy to our families, and we then seek reimbursement for the additional services from your insurance company only.

Below is a breakdown of care we provide and its related cost to you:

Procedure	Fee to Insurance	Your Fee
Office Consultation	$250.00	$250
Frenectomy (tongue tie release)	$600.00	$600
Additional frenectomy site (lip, cheek) – if needed	$995.00	$0
Re-release – if needed	$850.00	$0
Tissue removal/recontouring	$600.00	$0
Myofunctional stretching/massage	$100.00	$0
Post-operative follow up visit	$195.00	$0

Please note that medical insurance is billed through Dr. Soroush Zaghi, our ENT Medical Director, with Dr. Handa as the rendering provider.

We hope this information provides clarity and reassurance to you about our billing practices. Please let us know if there are any additional questions or concerns.

I have read the above information and have had the opportunity to seek answers to any remaining questions. I further understand that I will not be reimbursed for services covered by my insurance company that were not charged to me as the responsible party.

_____ _____

Responsible Party Signature Date

CREDIT CARD AUTHORIZATION FORM FOR LATE CANCELLATION

PATIENT NAME:_____ **DATE OF BIRTH:**_____

We honor our patients' time, as well as that of our team. When we create your appointment, we reserve a room to assess your needs, prepare your records, and well as specialized instruments for your visit. We ask that if you must change an appointment, please give us at least 24 hours notice. This courtesy makes it possible to give your reserved room to another patient in need.

There is a $100 charge for not showing up for scheduled appointments or cancelling appointments within 24 hours. Repeated cancellations or missed appointments will result in loss of future appointment privileges.

Acknowledged, Agreed & Accepted:
Having read this form, my signature below acknowledges that I provide my authorization for my credit card to be charged for services provided by Ratti Handa, D.M.D I certify that I am an authorized user of this credit card and thatI will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

*I ,*_____*, authorize Ratti Handa, D.M.D to charge my credit card $100 in the case of a last minute cancellation (under 24 hours notice) or no show of my child's appointment with*

Phone: _____ *Email:* _____

X_____
Patient/Card Holder Date: _____

X_____
Dr. Ratti Handa Date: _____

Payment Information

Type of Credit Card: Visa - MasterCard - Discover - Amex

Card Number: _____

Exp (__ __) **Security Code**: _____

Payment Amount: $100

Payment Type: One Time Charge