Pediatric & laser DENTISTRY
Nick A. Prater, DDS, LLC
Phone: 913.764.6222 | Fax: 913.764.5826 | Email: info@pediatricandlaserdentistry.com

Patients' name _____Birth date_____Today's date_____
Medical problems_____Heart disease_____Bleeding disorders_____Other_____
____Male ____Female ____Home birth ____Hospital birth ____Vaginal birth ____C-Section birth
Are you presently breastfeeding? ___Yes ___No If no, how long since you stopped breastfeeding?_____

Medical History: Has your child ever experienced any of the following problems or treatments?

1. Infants are usually given Vitamin K at birth to prevent bleeding in the first 8 weeks of life. Did you sign any waiver to refuse the administration of Vitamin K? ____Yes ____No
2. Was your infant premature? ___Yes ___No 3. Does your infant have any heart disease? ___Yes___No
4. Has your infant had any surgery? ___Yes ___No 5. Is your infant taking any medications?
___Reflux ___Thrush ___Other
Name of medication_____

6. Has your infant experienced any of the following?
___Poor latch
___Falls asleep while attempting to nurse
___Slides off nipple when attempting to latch
___Colic symptoms
___Reflux symptoms (due to excessive clicking and air intake)
___Poor weight gain
___Gumming or chewing of your nipple when nursing
___Unable to hold a pacifier in his/her mouth
___Short sleep episodes requiring feeding every 1-2 hours
___Snoring, heavy breathing, or any sleep apnea
___Waking up congested

7. Has your infant had a prior surgery to correct the tongue or lip tie?
___Yes ___No If yes when and where?
_____

Birth weight _____
Present weight _____

7. Do you have any of the following signs or symptoms?

___Creased, flattened, or blanched nipples after nursing
___Blistered or cut nipples
___Severe pain when your infant attempts to latch
___Mild pain when your infant latches
___Poor or incomplete breast drainage
___Infected nipples or breasts
___Plugged ducts or mastitis
___Nipple thrush

Dr. Prater may administer acetaminophen on infants over 2 months of age prior to surgery. Has your infant received any type of pain medication today? ___Yes ___No
Is it ok to give your infant pain medication?
___Yes ___No

Pediatrician_____Phone number_____
Address_____City_____State____ZIP_____
Lactation Consultant_____Phone number_____
Address_____City_____State____ZIP_____
Referred by_____Address_____
City_____State____ZIP_____
Did you use the internet to find our website? ___Yes ___No
Have you visited our website? ____Yes ____No
Additional comments?_____
_____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act or 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payors.

- Conduct normal healthcare operations such as quality assessments and physicians certification.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosers of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient name:_____

Relationship to patient:_____

Signature:_____

Date:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____