New Patient Registration

Child's Name: ______________________________ Birthdate:________________________________
Gender ___ Age: __________ Preferred Name: ____

Parent's Name: ___________________________Parent's Birthdate: __________________________
Cell:___________________ Alternate Phone Number: ______________________________________
Email:____
Address:____
Pediatrician:____
Who referred you to us?____

Medical History:

Any medical conditions or concerns for your child?
____
____

Any medications your child is taking? ____
Any allergies to foods or medications? ____
Any previous surgeries or had frenum clipped previously? _______________________________
Any other information we need to know? ____

By signing below, I acknowledge that I have read and received the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

To the best of my knowledge, I certify that the above information is complete and correct. I understand that it is my responsibility to inform this office of any changes in my child's medical status or any other information provided in this form.

I am the parent or legal guardian of ___________________ and I have authorization and ability to consent to treatment for this child. I do hereby request and authorize Cleveland Tongue-Tie Center to examine and perform treatment if necessary for the child named above.

Signature: ________________________________ Date:_______________________________