Shape

Description automatically generated with low confidence

New Patient Registration: Adult

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender \_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary care physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical History:

Any medical conditions or concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any medications you are 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 medical status or any other information provided in this form.

I have authorization and ability to consent to treatment for myself. I do hereby request and authorize Tongue-Tie Dental PLLC to examine and perform treatment if necessary.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADULT ASSESSMENT**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medications taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous clip or release of tongue? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(date)

**1. Have you experienced any of the following issues? Please check or elaborate as needed.**

**Speech Issues**

\_\_\_ Others have a hard time understanding speech

\_\_\_ Embarrassed with communication

\_\_\_ Shy in social situations

\_\_\_ Difficulty speaking fast

\_\_\_ Difficulty getting certain words out

\_\_\_ Trouble with sounds (which?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Speech delay (when?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Stuttering

\_\_\_ Jaw gets tired when talking or reading aloud

\_\_\_ Speech harder to understand in long sentences

\_\_\_ Speech therapy (how long)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Mumbling or speaking softly

\_\_\_ Difficulty singing

**Feeding Issues**

\_\_\_ Breastfed or \_\_\_ Bottle-fed as a baby

\_\_\_ Fussy, colicky, or “difficult” as a baby

\_\_\_ Frustrated when eating currently

\_\_\_ Slow eater (last one to finish a meal)

\_\_\_ Small appetite

\_\_\_ Graze on food throughout the day

\_\_\_ Pack food in cheeks

\_\_\_ Picky with textures (which?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Difficulty swallowing pills

\_\_\_ Choking or gagging on food or water

**Breathing Issues**

\_\_\_ Trouble breathing through nose

\_\_\_ Mouth open / mouth breathing during the day

\_\_\_ Tonsils or adenoids removed previously

\_\_\_ Sinus issues or sinus surgery

\_\_\_ Teeth extracted for braces

\_\_\_ Jaw surgery in past

**Sleep Issues**

\_\_\_ Sleep in strange positions

\_\_\_ Move around a lot at night

\_\_\_ Wake easily or often

\_\_\_ Poor quality sleep

\_\_\_ Wake up tired and not refreshed

\_\_\_ Sleep appliance or CPAP needed at night

\_\_\_ Grind teeth while sleeping

\_\_\_ Sleep with mouth open

\_\_\_ Snore while sleeping (how often) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Gasp for air or stop breathing (sleep apnea)

**Other Related Issues**

\_\_\_ Neck or shoulder pain or tension

\_\_\_ TMJ Pain, clicking, or popping

\_\_\_ Headaches or migraines

\_\_\_ Strong gag reflex

\_\_\_ Prolonged thumb sucking

\_\_\_ Ear tubes previously or lots of ear infections

\_\_\_ Reflux (if so, medication?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Constipation

\_\_\_ Hyperactivity / inattention

\_\_\_ Stress or anxiety

\_\_\_ Trouble or pain with kissing / intimacy

\_\_\_ Don’t hold chiropractic adjustments well

**Anything Else We Need to Know:**

Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Myofunctional Therapist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you to us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_