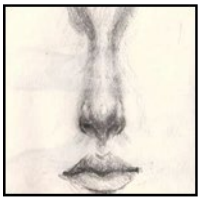


Savannah Sleep Consultant LLC
Douglas E. Smith, DDS

Preparing for a Revision appointment

Thank you for trusting us with you child! We take that trust very seriously!
We are providing, for you, an integrative model of care, to address all needs the day of the procedure.
We are honored to serve your family in working through issues of oral restrictions.

What to have at home before the procedure

- A baby carrier (woven wrap, soft structured carrier, Moby, etc.) for doing skin to skin contact for an extended period.
- Turmeric
- Tylenol/Ibuprofen
- Arnica Gel/Massage Oil or heavily diluted essential oils as appropriate for your child's age if desired (essential oils should not be used on babies younger than 3 months)
  You can use coconut oil. *Please, no vitamin E*, as this will accelerate healing.
- Epsom Salt and/or Magnesium Oil
- Cool compress
- Scheduled appointment with a properly trained Bodyworker (LMBT, CST, DC)
- Scheduled appointments with an IBCLC or SLP who is educated about tongue tie (ankyloglossia)
- Swallow size ice chips- with or without turmeric
  Turmeric and breastmilk/formula mixture– 1/8 tsp of turmeric to 1oz breastmilk/formula.
  (use turmeric for improved reduction of inflammation)
  You can make these by pouring breastmilk/formula into a small zip lock bag and freeze flat, then break into SMALL swallow size chips.
- Refrigerated Wound Healing Tincture (This will be given to you when you come in for the procedure)

How do we prepare?

It's best to plan to be at the office for as long as 2 hours. Please bring anything you currently use for feeding. While at the office, you will only need tools for feeding and perhaps a good soft carrier (sling, pouch, backpack style, wrap). You may consider bringing snacks for yourself. Please feel free to contact the office with any questions about billing ahead of time so that we can all focus on care the day of.

What do we expect?

Your time with us, the day of the procedure, will be support focused. All care will center around a support group that will include other families also planning to have frenectomies in the same space. We recommend bringing someone with you that can help support you through this experience.

Surrounding that, you will receive a thorough diagnosis, education on healing, training on aftercare, myofascial preparation for your child, laser release of any restrictive tissues identified through functional and physical assessment, guidance during feeding immediately following the procedure, and tools for equipping your baby with the resilience that we know is possible. This remarkable full model of care will take 90 minutes to 2 hours and hopefully leave you confident in moving forward with equipping your child with the gift of full oral function, for a lifetime.

The evening of the procedure is a good time to plan to be home (or somewhere private). Most babies have soreness that evening and need extra support through skin to skin contact, babywearing, co-bathing, distraction, analgesics, and calming presence. You know your child best, as far as what will help them get through this period of soreness and can plan accordingly. The day after the procedure is often one filled with progress and is a good time to plan to spend the day focused on practicing breastfeeding, solids, speech, or any other skills previously handicapped by oral restrictions. The days following this day of progress will include periods of muscle soreness from moving in a new range of motion, interspersed with periods of progress. The site of the release itself should not actively hurt after the day of the procedure, but you will be performing intraoral aftercare frequently for 7-10 days post op. We suggest considering this need in plans you make for childcare, travel, or holidays during this time frame. We recommend planning a follow-up with us about 1 week post procedure, as well as with your IBCLC/SLP and bodyworker. Success will be a process!

Ultimately, you can expect one big day followed by about one month of extra work, resulting in full oral function. Making this investment now can prevent many issues that degrade quality of life long term. We realize many parents are feeling overwhelmed and we are here to support you through the process. We are happy to answer any questions or address any concerns you have. This is something you're doing for your baby and is really the gift of a lifetime. We're honored to be part of this process.

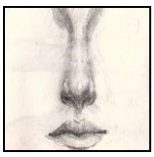
Dr. Douglas Smith and his team believe in a comprehensive, team approach..
This is why we request a functional assessment from an IBCLC or SLP who is educated in tongue and lip ties before scheduling the procedure. We rely on experts in feeding/speech to assess functionality and provide care for rehabilitation afterward. Additionally, since the procedure affects the muscles, we recommend bodywork for 48 hours before the procedure to prepare both the muscles and nervous system for this, often dramatic, change. We have found that the entire process goes far more smoothly and everyone is happier with this multifaceted approach. If it is not followed, we cannot ensure optimal results from the procedure alone.

We will provide educated expectations as well as bodywork the day of the consultation. Be prepared to spend the evening after the procedure at home focused on comforting your child. They will be dedicated to practicing new skills (such as nursing a lot). We understand that you may be nervous or apprehensive and that is understandable. Most parents are surprised at just how resilient babies can be! Remember that this is something you're doing for your baby to enable a lifetime of health and wellbeing! We are happy to answer your questions and provide what you need to feel confident in our care. Dr. Smith has been through this experience himself and is happy to help in any way he can.

Sincerely,
Dr. Smith and the Savannah Sleep Consultant team

Savannah Sleep Consultant

Douglas E. Smith DDS, D.ABCDSM, D.ABDSM, D.ACSDD



Welcome to our office! We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided is important to your dental health. If there have been any changes in your child's health, please let us know.

Childs Name: _____ Date of Birth: _____ Sex: M / F
Parent/Guardian Name: _____ Email: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Primary Phone #: _____ Alternate Phone #: _____
SS#: _____ Employer/Occupation: _____
Emergency Contact Name: _____ Phone #: _____
Relationship: _____

Child's Pediatrician: _____ Office Phone #: _____
Would you like us to send today's procedure notes to your child's physician? Yes No
Lactation Consultant: _____ Phone #: _____
Body Worker/Chiropractor: _____ Phone #: _____
Speech Language Pathologist: _____ Phone #: _____

Primary Medical Insurance: _____ Subscriber ID: _____
Name of Subscriber: _____ Subscriber Date of Birth: _____
Primary Dental Insurance: _____ Subscriber ID: _____
Name of Subscriber: _____ Subscriber Date of Birth: _____
*If baby is not yet on insurance plan, when is the expected date of enrollment?: _____

Financial Policy

I hereby authorize assignment and payment directly to Savannah Sleep Consultant and the release of any information necessary to process my insurance. Savannah Sleep Consultant requires payment at the time treatment is rendered. Dr. Smith is not responsible for determinations made by insurance companies in decisions to cover necessary procedures. We will do our best to work with your insurance company in providing necessary information explaining the diagnosis and treatment presented. A fee of $25 is charged for patients who miss or cancel more than 1 appointment without a 24 hour notice. Should it become necessary for us to consult a third party concerning your account, you will be responsible for any and all related fees during the collection process.

Signature: _____ Date: _____

Patient Name: _____ Parent/Guardian (Print): _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name (Print): _____

Name of person giving consent: _____

Person Involved With Care:
List individuals whom you would like involved in your dental care. By writing their names below, you consent to the release of your dental information to them (ex: spouse, children, etc.) This includes discussions on all related treatment, insurance payments, and patient payments. In addition, the account holder (not necessarily the insurance holder) may receive basic dental treatment information on mailed billing statements.

_____ _____

_____ _____

Purpose of Consent:
By singing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. If you decide not to sign this consent, we may decline to treat you. You have the right to read our Notice of Privacy Practices prior to signing this form. Please request this notice from the front desk if you would like a copy.
I have read and consider the contents of this consent form. I understand that by signing below, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.
Patient Name (Print): _____ Date: _____

Patient Signature: _____

Name of Person Signing (If not patient): _____

Relationship to Patient: _____

Informed Consent for the Treatment of Frenectomy to Infant

After a thorough oral examination, Dr. Smith has advised me that the reduction of a frenum(s) attachment in my child's mouth may help to restore anatomy, function, and/or possibly prevent commonly associated future problems.

Patient safety: I understand that a swaddle blanket may be used to gently ensure my child's safety during the frenectomy procedure (applies to infants only). Mouth props will likely be utilized for older children. Protective eyewear must be worn by all people present in the treatment room, including my child. I understand all of the previous are for my child's safety.

Principle complications: I understand that a smooth recovery is expected, however, there are always associated risks that cannot be eliminated and may occur in a small number of cases. These complications include but are not limited to post-surgical bleeding, infection, swelling, pain, damage to adjacent structures such as salivary glands, nerve, muscle, and skin. Such complications may require care from an additional healthcare provider such as an oral surgeon. A common complication is re-attachment of the frenum. Genetics also plays a strong role in healing, such as the formation of a scar, keloid, or overt fibrous tissue formation.

Post- op care and follow up: I understand that I must follow the daily therapy exercises instructions for up to 21 days to lessen the risk of frenum reattachment. I am advised to return for a one-week post-op to evaluate healing of the frenum area.

Photos: Pre-op and post-op photos may be taken for documentation and insurance purposes, but not of the face without permission.

Alternatives to suggested treatment: I understand that alternatives to a frenectomy include: no treatment, with the expectation that the frenum does not normally improve with age but may aggravate the surrounding tissues including the gums and teeth. Also, an alternative to a frenectomy by my dentist is to seek the care of another healthcare professional, including but not limited to doctors of general dentistry, periodontics, oral surgery, ENT, and plastic surgery. The use of the laser itself can be deferred to more traditional instruments of care.

No warranty or guarantee: I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed treatment will be successful. I do expect, however, that Dr. Smith will perform the surgery to the best of his ability.

RISKS OF PROCEDURE

While the majority of patients have an uneventful surgery/procedure and recovery, a few cases may be associated with complications. There are some risks/complications, which can include:

- Bleeding: This may occur either at the time of the procedure or in the first 2 weeks after.
- Infection
- Pain
- Damage to sublingual gland, which sits below the tongue. This may require further surgery.
- Injury to the teeth, lip, gums, or tongue
- Burns from the equipment
- The frenum can heal back and require further surgery.

- Swelling and inflammation, especially of upper lip
- Scarring is rare but possible
- Eye damage if baby looks directly into the laser beam. Complete eye protection is mandatory and will be worn by baby and staff

Necessary Follow Up Care

I understand that failure to follow Dr. Smith's recommendations could lead to undesired outcomes, which are my sole responsibility. I will need to come to follow up appointments after the procedure so that healing may be monitored and for the doctor or lactation consultant to evaluate and assess the outcome upon healing completion. Smoking and alcohol may adversely affect healing and may limit successful healing. I understand it is imperative to follow the specific instructions given by Dr. Smith. I understand that I must follow the daily therapy exercises instructions for up to 21 days to lessen the risk of frenum reattachment. I am advised to return for a one-week post-op to evaluate healing of the frenum area.

PARENT CONSENT

I acknowledge that the doctor has explained my child's condition and the proposed procedure. I understand the risks of the procedure, including the risks that are specific to my child and the likely outcomes. I was able to ask questions and raise concerns with the doctor about my child's condition, the procedure and its risks, and treatment options. My questions and concerns have been discussed and answered to my satisfaction. I understand that photographs or video footage may be taken during my child's procedure and these may be used for teaching health professionals. I understand that no guarantee has been made that the procedure will improve the condition and that the procedure may make my child's condition worse. I understand that my child may need another procedure if the initial results are not satisfactory. I understand and
agree to stretch and massage the areas, retraining the proper latch, and referring to a lactation consultant, chiropractor, or Cranial Sacral Therapist to help with post-op soreness. I understand that other factors affecting milk supply could be interfering, including but not limited to: medicines, stress, smoking, pituitary dysfunction, pain, irregular feeding routines, impaired let down.
On the basis of the above statements, I REQUEST THAT MY CHILD HAS THE PROCEDURE

Name of Patient: _____Date:_____

Signature of Parent/legal guardian: _____Date:_____

Witness:_____