Brewer Dental Specialists, P.A.

Carey L. Fister, DMD
Diplomate, American Board of Pediatric Dentistry
237 Wilson Street, Brewer, ME 04412
Phone: (207) 991-9580 Fax: (207) 991-9588

"Transforming Children's Smiles Into Beautiful Faces"

Today's Date:____/_____/____

Patients Name:_____ Male____ Female____

Home Phone:_____ Cell# (Mom):_____ Cell #(Dad):_____

Date of Birth:_____/_____/_____ Age:_____ Social Security Number:_____

Mailing Address:_____ City: _____ State:_____ Zip:_____

Street Address if different from Mailing Address:_____ City: _____ Zip:_____

Patients Dentist:_____ Patients Physician:_____

Whom may we thank for referring you to our office? Dentist_____ Yellow Pages_____ Other:_____

Mother/Stepmother's Name:_____ Social Security Number:_____ D.O.B:_____

Employed By:_____ Occupation:_____

Business Address:_____ Phone:_____

____SINGLE ____MARRIED____SEPARATED____DIVORCED____WIDOWED

Father/Stepfather's Name:_____ Social Security Number:_____ D.O.B:_____

Employed By:_____ Occupation:_____

Business Address:_____ Phone:_____

_____Yes Due to Federal HIPPA Guidelines, I have reviewed a copy of the Notice of Privacy Practices when I arrived for my appointment. I hereby give permission for this office to discuss treatment, schedule appointments, & or finances for the above patient to immediate family members
____YES ____NO

**** Full payment is due at the time of service. Dr. Fister is a participating provider with Delta Dental insurances only. We are OUT OF NETWORK for all other insurance companies. By my/our signatures(s) I /we agree to accept full financial responsible for the child(ren) listed below. There is a $25.00 fee for any checks returned by the bank for any reason plus any additional charges for the bank issuing a bank check. If I default on this agreement, I understand I will be charged 18% per annum in late fees on any outstanding balance and I will also be responsible for any/all associated costs for court or collection action of any type. If I /we default on payment to BDSPA that I/we will be liable to the extent permitted by law, for BDSPA's collection, court costs, and attorney fees, in collecting this account.****

BOTH PARENTS SIGNATURES ARE REQUIRED

SIGNED BY **PARENT /LEGAL GUARDIAN** (***MOTHER/STEPMOTHER***-FATHER/STEPFATHER) Please Circle One

SIGNED BY **PARENT /LEGAL GUARDIAN** (MOTHER/STEPMOTHER-***FATHER/STEPFATHER***) Please Circle One

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME:_____

Insurance Claims Mailing Address:_____ 1-800#_____

Subscriber:_____ Certificate or ID#:_____ Group:_____

Subsribers Address if different from the patient:_____

Patients Relationship to insured subscriber:_____ SON/STEP SON_____ DAUGHTER/ STEPDAUGHTER_____

Secondary INSURANCE COMPANY NAME:_____

Insurance Claims Mailing Address:_____ 1-800#:_____

Subscriber:_____ Certificate or ID#:_____ Group:_____

Subsribers Address if different from the patient:_____

Patients Relationship to insured subscriber:_____ SON/STEP SON_____ DAUGHTER/ STEPDAUGHTER_____

Medical History

- Is your child currently under a physicians care? YES / NO Please List: _____
- Has your child ever been hospitalized for a major operation? YES / NO Please List: _____
- Please list current medications your child is taking:

_____

_____

_____

- Is your child allergic to any of the following: (Please ***Circle)***

ACRYLIC / AMOXICILLIN / CODEINE / LATEX / LOCAL ANESTHETICS / PENICILLIN / METAL / SULFA DRUGS

Other: _____

_____

- Please ***circle*** the following if your child has been diagnosed and/or treated for any of the following:

*AIDS/HIV	*Excessive Bleeding	*Stomach/ GI Disease	*MRSA
*Anemia	*Frequent Headaches	*Tuberculosis	*Physical Delays
*Asthma	*Heart Condition/ Murmur	*Congenital Birth Defects	*Sensory Delays
*Blood Disorder/ Transfusion	*Hepatitis A, B or C	*Cerebral Palsy	* Speech / Hearing Problems
*Cancer/ Tumors	*Kidney Disease	*Cleft Lip/ Palate	
*Diabetes	*Liver Disease	*Frequent Infections	*Other
*Epilepsy/ Seizures	*Rheumatic Fever	*Mental Delays / Autism	

Please elaborate on any items circled or if your child has any serious illness not listed above:

_____

_____

_____

Dental History

- Does your child take fluoride supplements? YES / NO
- Is this the first dental appointment for your child? YES / NO

Dentist: _____ When: _____

- When were most recent radiographs (X-rays) taken? _____ Office: _____
- Has your child ever had local anesthetic (Novocaine)? YES / NO
- Does your child participate in any sports or activities? YES / NO Please List: _____
- How would your describe your child's temperament?

_____

- Has your child had any unfavorable dental experiences? YES / NO

If yes, please explain:

_____

_____

_____

- Is there anything in particular that you would like examined or answered for you today?

_____

_____

To the best of my knowledge, the questions on the form have been accurately answered. I understand that providing incorrect information can dangerous to my child's health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PARENT OR LEGAL GUARDIAN: _____ DATE: _____

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PATIENTS NAME:_____

Financial Disclosure & Dental Insurance Policy

All fees for treatment are due at the time services are rendered. Brewer Dental Specialists is a participating provider with Delta Dental Insurance only. Our office is **OUT OF NETWORK** for all other insurance companies. Our office will submit claims for you to help reduce your families out of pocket expense and any balance not covered by insurance is due within 30 days. However, insurance is a contract between you and your insurance company and insurance companies pay based on the percentage of charges submitted. Families need to understand that insurance pays a percentage based on "their fee schedule" and not necessarily by the percentage of fees in our office. Fees not covered by your insurance company may include deductibles, co-payments or certain procedures not covered by your dental insurance company. ***It is the responsibility of the subscriber to keep track of the yearly allowances used and any/all limitations, restrictions, or waiting periods pertinent to coverage***. Therefore, we will ***estimate*** the benefits of your dental insurance before each treatment and will collect ***estimated portion*** which your insurance company is not expected to pay. Our office is not responsible for how your insurance company processes claims. Our office does not guarantee payment from your insurance company and ONLY provides you with an estimate until the claims process. It is our office policy to obtain both parents Social Security Numbers in order to expedite the claims process. If you choose to refuse to provide your Social Security Number we will gladly provide you with an insurance claim form so you can privately submit to your insurance company. However, the entire treatment cost would be due in full at each visit and our office will only be able to accept cash or a credit card for payment.

If your insurance company doesn't process the claim within 30 days our office will notify you by phone and you will be responsible for the full payment within 10 days.

A monthly charge of $5 in late fees will be added to any outstanding balance past 30 days. There is a $25.00 fee for any checks returned by the bank for any reason. If I default on this agreement, I understand I will be charged 18% per annum in late fees on any outstanding balance and I will be responsible for any/all associated costs for court or collection action of any type. By my/our signature(s) I /we also agree to accept full financial responsibility for the child(ren) listed above. If I/we also agree if I/ we default on payment to BDSPA I/we will be liable to extent permitted by law, for BDSPA's collection costs, court costs, and attorney fees, in collection this account.

Appointment Cancellation Policy

Our office reserves the right to charge a ***$25.00*** fee for **any** appointments that are missed or rescheduled less than 24 hours. Two or more failed appts, late changes or late cancellations is grounds for dismissal from our practice.

Informed Consent for Treatment

I grant permission to Dr. Carey Fister and staff of Brewer Dental Specialists Staff to provide my child's dental treatment which may include, but is not limited to: oral examinations, fluoride placement, prophylaxis, radiographic needs, restorative work, local anesthetic, nitrous oxide, oral midazolam administration, extractions, space maintainers, behavior management, and protective stabilization techniques which are reasonable, necessary, and advisable for the treatment of children ***at certain times***. The risks, benefits, and alternatives of all treatment and techniques have been discussed with me and my questions have been answered. I fully acknowledge the recommended treatment plan is a biological procedure and holds no guarantee. I understand Dr. Carey Fister has not made any warranties or guarantees concerning treatment and long term success of treatment. If, during treatment, unforeseen conditions are revealed which necessitate an extension of the original procedure or a different procedure than planned, I authorize such procedures as are necessary and desirable in the exercise of professional judgment. This consent to treatment shall remain in effect until such time it is revoked by written notice to this office. I understand I will not be required to sign consent for each visit while my child is a patient of record at Brewer Dental Specialists.

By signing below, I attest that I understand the Informed Consent for treatment and grant such consent.
By signing I also consent to the appointment cancellation policy and Financial Disclosure.
**********WE REQUIRE BOTH PARENTS SIGNATURES.**********

SIGNED PARENT /LEGAL GUARDIAN (mother/stepmother-father/stepfather) Please Circle ONE DATE

SIGNED PARENT /LEGAL GUARDIAN (mother/stepmother-father/stepfather) Please Circle ONE DATE