First State
Oral & Maxillofacial Surgery

Douglas Ditty, D.M.D., M.D., Franklin X. Pancko, D.D.S.
Rhae A. Riegel, D.M.D., M.D., & Nicholas J. Alcorn, D.M.D.

Patient Name:	Guarantor Name: D.O.B.:
Address:	Address:
City: State: Zip:	City: State: Zip:
Home #: Cell #: Email:	Home # : Cell # : Guarantor S.S. #:
D.O.B.: SS #:	Preferred Pronoun:
Single Married Other Gender on insurance policy: Female Male General Dentist: Primary Care Physician:	Insurance Policy Holders Address: Secondary Policy Holders Address:

***Emergency Contact*: _____ Telephone _____**

PRIMARY MEDICAL INSURANCE Name of Company: Policyholder's Name: Member ID # Grp#	**PRIMARY DENTAL INSURANCE** Name of Company: Policyholder's Name: Member ID# Grp#
Policyholder's SS#:	Policyholder's SS#:
Policyholder's DOB:	Policyholder's DOB:
Employer:	Employer:
Relationship to Policyholder: Self Child Spouse Other:_____	Relationship to Policyholder: Self Child Spouse Other:_____
SECONDARY MEDICAL INSURANCE Name of Company: Policyholder's Name: Member ID # Grp#	**SECONDARY DENTAL INSURANCE** Name of Company: Policyholder's Name: Member ID# Grp#
Policyholder's SS#:	Policyholder's SS#:
Policyholder's DOB:	Policyholder's DOB:
Employer:	Employer:
Relationship to Policyholder: Self Child Spouse Other:_____	Relationship to Policyholder: Self Child Spouse Other:_____

DUE TO NEW LAW, WE NOW NEED WRITTEN PERMISSION FROM YOU (the patient or parent/legal guardian of a minor) to leave messages on an answering machine, with someone in the household, or workplace about your appointments. By signing below, you give permission to call.

SIGNATURE _____ DATE_____

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Delaware Medicaid Dental Program Patient Financial Responsibility Agreement

The Delaware Medicaid Dental Program does not pay for everything, even some services that your health care provider recommends. As a contracted provider, we will bill you for these services, but must not charge more than our usual and customary rate.
Additionally, the Delaware Medicaid Dental Program has limitations on how frequently some services will be paid, as well as a maximum benefit amount per year. If your benefit limits have been exhausted (either frequency or amount), you may still choose to have services provided, and we will bill you for those services at the Medicaid fee schedule rate.

Patient Name: _____ Date Of Birth: _____

By signing this form, you are agreeing to pay for some or all of the services that may not be covered. You may change your mind up to 24 hours before treatment is rendered.

I, _____ agree to accept financial responsibility should the dental service(s) provided not be covered.
Provided Service:

- Consultation
- Consultation and Xray
- See attached treatment plan

I understand I am being charged a fee for these dental services because:

- These services are not covered by Delaware Medicaid (Delaware Medicaid will not pay for this dental service).
- These services are covered by Delaware Medicaid, but I have exceeded my program limits (I have already used up coverage for dental services for this year).

I further agree that:

- I understand I must pay for these services on my own. I also understand that reimbursement is NOT available from your MCO and/or Delaware Medicaid.
- My provider has clearly explained other service options that may be covered under my plan, and I understand those options.
- I understand there are other options for obtaining these services at a free or reduced cost from public health or educational institutions.

Patient/Guarantors Signature _____ Date _____

****Medicaid member or representative who is legally authorized to sign this document.**

IF THIS FORM DOES NOT APPLY, PLEASE FILL OUT INFORMATION BELOW

I, _____ Patient/legal guardian state that I do not have Medicaid as an insurance and that this form does not apply.
Signature: _____ Date: _____

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Patient Contract – Provider Opt-Out of Medicare

Providers: Douglas Ditty, DMD, MD; Franklin Pancko, DDS; Rhae Riegel, DMD, MD; Nicholas Alcorn, DMD

Beneficiary Name:

Legal Representative (if applicable):

This patient contract agreement is between the provider and beneficiary noted above. The beneficiary is a Medicare beneficiary and is seeking services covered under Medicare. This agreement is to inform the beneficiary or his/her legal representative that the providers have opted out of the Medicare Program. The beneficiary or his/her legal representative has read and agreed to the following terms of the patient contract by placing their initials by the items below:

- I, or my legal representative, accept full responsibility for payment of the provider's charge for all services furnished by the provider;
- I, or my legal representative, understands that Medicare limits do not apply to what the provider may charge for items or services furnished by the provider;
- I, or my legal representative, agree **NOT** to submit a claim to Medicare or to ask the provider to submit a claim to Medicare;
- I, or my legal representative, understand that Medicare payment will not be made for any items or services furnished by the provider that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted;
- I, or my legal representative, enter into the contract with the knowledge that the beneficiary has the right to obtain Medicare-covered items and services from providers who have not opted out of Medicare, and that the beneficiary is not compelled to enter into private contracts that apply to other Medicare covered services furnished by other physicians or practitioners who have not opted out;
- I, or my legal representative, understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare;
- I, or my legal representative, agree this contract was not entered into during a time when the beneficiary required emergency care services or urgent care services.

Beneficiary or Legal Representative's Signature

Date

IF THIS FORM DOES NOT APPLY, PLEASE FILL OUT INFORMATION BELOW

I, _____ Patient/legal guardian state that I do not have Medicare as insurance and that this form does not apply.

Signature: _____ Date: _____

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DOUGLAS DITTY, D.M.D., M.D., FRANKLIN X. PANCKO, D.D.S.
RHAE A. RIEGEL, D.M.D., M.D., & NICHOLAS J. ALCORN, D.M.D.

1004 S. State Street, Suite 1
Dover, DE 19901
302-674-4450

9096 Riverside Dr.
Seaford, DE 19973
302-629-3588

19323 Lighthouse Plaza Blvd #4
Rehoboth Beach, DE 19971
302-226-1606

FIRST STATE ORAL AND MAXILOFACIAL SURGERY ASSOCIATES, CORP.
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, First State Oral & Maxillofacial Surgery Corp. may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Please refer to First State Oral &Maxillofacial Surgery Corp. Notice of Privacy Practices for more complete descriptions of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. First State Oral & Maxillofacial Surgery Corp. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to First State Oral &Maxillofacial Surgery Corp. at 1004 S. State Street, Dover, DE 19901.

With my consent, First State Oral & Maxillofacial Surgery Corp. may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, First State Oral & Maxillofacial Surgery Corp. may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment cards, insurance items, healthcare forms, and patient statements as long as they are addressed to the individual or marked personal and confidential.

I have the right to request that First State Oral & Maxillofacial Surgery Corp. restrict how it uses or discloses my PHI to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to First State Oral & Maxillofacial Surgery Corp. use and disclosure of my protected health information to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior request. If I do not sign this consent, First State Oral & Maxillofacial Surgery Corp. may decline to provide treatment to me.

_____ _____ _____
Signature of Patient or Legal guardian **Printed Name of Patient or Legal guardian** **Date**

_____
Relationship to Patient

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES
By signing this authorization, I authorize First State Oral & Maxillofacial Surgery Corp. to use and/ or disclose certain protected health information about me to or for the party or parties listed below.
This authorization permits FSOMS to use or disclose to: _____

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that First State Oral & Maxillofacial Surgery Corp. has noted in reliance upon this authorization. My written revocation must be submitted to First State Oral & Maxillofacial Surgery Corp. at 1004 S. State Street, Suite 1, Dover, DE 19901.

_____ _____ _____
Signature of Patient or Legal guardian **Printed Name of Patient or Legal guardian** **Date**

_____
Relationship to Patient

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Financial Policies

Patients are required to pay in full the day of service. Cash, Visa, MasterCard, Discover, American Express or Care Credit are accepted forms of payment.

REGISTRATION:

- All patients must complete our patient information registration, which will be entered into our computer to maintain accurate information for proper billing. We must obtain a copy of your driver's license and current valid insurance cards to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of a claim. Most insurance companies have time filing restrictions; if a claim is not received within 30 days of the date of service, it can be rendered ineligible for payment, and you will be responsible for the balance that remains.

PATIENTS WITH INSURANCE COVERAGE

- We will submit the claim to your insurance carrier as a courtesy to you. However, you are responsible for the payment of the account, and responsible for resolving any problems with your insurance company.
- We will check your insurance carrier for your benefits and give you an **ESTIMATE** of the fee for service prior to your surgery. However, the estimate is not a guarantee of payment until the claim is finalized with your insurance company. Any remaining balance will be billed to you as your responsibility. Sometimes there could be a balance from a coinsurance, deductible or over maximum after the claim is finalized regardless of what estimate was given to our staff by the insurance company. **ANY ESTIMATES ARE NOT A GUARANTEE.**
- Non-Covered services for your appointment is due at the time of service. Please keep in mind that treatment can change after seeing the physician which may result in an additional out of pocket amount that was not previously estimated.

PATIENTS WITH NO INSURANCE COVERAGE

- Self-pay patients' total amounts for their appointment are due at the time of service. Please keep in mind that treatment can change after seeing the physician which may result in an additional out of pocket amount.

REFUNDS

- Any patient that is due a refund over $50 will have a reimbursement check written following the receipt of the patient's insurance payment or explanation of benefits and mailed to the address on file.
- Refunds of $50 or less will be left as a credit on the patient's account.

ADDITIONAL TERMS

- Surgery appointments that are canceled with less than 72 business hour's notice are subject to a $100 cancellation fee. This fee is not billable to any insurance and will be the sole responsibility of the patient/guarantor.
- Consultation appointments that are canceled with less than 72 business hour's notice are subject to a $50 cancellation fee. This fee is not billable to any insurance and will be the sole responsibility of the patient/guarantor.
- All sedation patients whose designated driver and vehicle leaves the property will be charged an additional anesthesia monitoring fee of $100 per 30 min increment. This fee is not billable to any insurance and will be the sole responsibility of the patient/guarantor.
- Any check that is returned by a bank for Non-Sufficient Funds are subject to a minimum $40 processing charge.
- Any account that is greater than 90 days Past Due will be turned over to our Collection Agency, and due to the administrative charges, you will be subject, in addition, to a collection cost of 37% of the account balance. You may also be responsible for any court costs and reasonable attorney fees. Once your account is sent to collections, you cannot be treated in this office until that balance is $0.

I HAVE READ THE ABOVE AND UNDERSTAND THE FINANCIAL POLICY OF FSOMS.

Patient Name: _____

Signature of Patient or Legal Guardian: _____ Date:_____

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HEALTH HISTORY

Patient Name: _____ Date Of Birth: _____ Height: _____ Weight: _____lbs
Preferred Pronoun: HE/HIM/HIS SHE/HER/HERS THEY/THEM/THEIR Other:_____
Preferred Pharmacy: _____ Location of pharmacy (zip code): _____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why?_____
4. Yes No Are you being treated by a physician now? For what? _____
   Date of last medical exam?_____Date of last Dental exam_____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. DO YOU HAVE OR HAVE YOU HAD:

7. Yes No Chest pain (angina)?
8. Yes No Swollen ankles?
9. Yes No Shortness of breath?
10. Yes No Recent weight loss, fever, night sweats?
11. Yes No Persistent cough, coughing up blood?
12. Yes No Bleeding problems, bruising easily?
13. Yes No Sinus problems?
14. Yes No Difficulty swallowing?
15. Yes No Psychiatric care?
16. Yes No Joint pain, stiffness?
17. Yes No Dizziness?

SECOND SECTION:

18. Yes No Fainting spells?
19. Yes No Seizures?
20. Yes No Headaches?
21. Yes No Prosthetic heart valve?
22. Yes No Artificial joint?
23. Yes No Blood transfusions?
24. Yes No Surgeries?
25. Yes No Pacemaker?
26. Yes No Radiation treatments?
27. Yes No Chemotherapy?
28. Yes No Hospitalization?

III. DO YOU HAVE OR HAVE YOU HAD:

29. Yes No Heart disease?
30. Yes No Heart attack?
31. Yes No Heart murmurs?
32. Yes No Rheumatic fever?
33. Yes No Stroke, hardening of arteries?
34. Yes No High blood pressure?
35. Yes No Asthma?
36. Yes No Liver disease?
37. Yes No Stomach problems, ulcers?
38. Yes No **Allergies to: foods ☐, medications ☐, latex ☐?**
    Please list allergies:_____
39. Yes No Family history of:_____

SECOND SECTION:

40. Yes No AIDS, HIV?
41. Yes No Tumors, cancer?
42. Yes No Arthritis, rheumatism?
43. Yes No Diabetes?
44. Yes No Skin diseases?
45. Yes No Anemia?
46. Yes No Emphysema, other lung disease?
47. Yes No Herpes?
48. Yes No Kidney disease?
49. Yes No Thyroid, adrenal disease?
50. Yes No Sleep Apnea?
51. Yes No Heart Defects?
52. Yes No Hepatitis **A☐ B☐ C☐**

Please List Medications Currently Taking Or Show Medication list:

VII. ALL PATIENTS:

Yes No Do you have, or have you had any other diseases or medical problems NOT listed on this form? If so, please explain: _____

IV. ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING, CIRCLE ALL THAT APPLY:

Blood Thinners: ELIQUIS XARELTO WARFARIN(COUMADIN, JANTOVEN) PLAVIX(CLOPIDOGREL) BRILINTA
OTHER: _____

Bisphosphonates: Fosamax Boniva Reclast Prolia Xgeva OTHER: _____

Weight Loss Injection/Diabetes: Wegovy Ozempic Zepboud Mounjaro Contrave Jardiance OTHER: _____

V. ARE YOU TAKING:

53. Yes No Cannabis?
54. Yes No Any other recreational drug use: _____

SECOND SECTION:

55. Yes No Tobacco in any form?

VI. WOMEN ONLY:

57. Yes No Are you or could you be pregnant or nursing?
58. Yes No Taking birth control pills?

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature:_____ Date:_____

RECALL REVIEW:

1. Patient's signature: _____ Date:_____