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#: **Work#:** **Cell#:** **Email:**	**Home# :** **Cell# :** **Email:** **Guarantor S.S. #**
D.O.B.: SS#:	
Single **Married** **Other** **Gender on insurance policy: Female** **Male** **General Dentist:** **Primary Care Physician:**	**Preferred Pronoun:** **HE/HIM/HIS** **SHE/HER/HERS** **THEY/THEM/THEIR** **Other: ________________**

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**:
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**:

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

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__________________

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

First State
Oral & Maxillofacial Surgery

HEALTH HISTORY

Patient Name: ____ Date Of Birth: ______________

Height: ___________ Weight: ________lbs

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. HAVE YOU EXPERIENCED:

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 Diarrhea, constipation, blood in stools?
16. Yes No Frequent vomiting, nausea?
17. Yes No Difficulty urinating, blood in urine?
18. Yes No Dizziness?
19. Yes No Ringing in ears?
20. Yes No Headaches?
21. Yes No Fainting spells?
22. Yes No Blurred vision?
23. Yes No Seizures?
24. Yes No Excessive thirst?
25. Yes No Frequent urination?
26. Yes No Dry mouth?
27. Yes No Jaundice?
28. Yes No Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29. Yes No Heart disease?
30. Yes No Heart attack, heart defects?
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, TB, emphysema, other lung diseases?
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 diabetes, heart problems, tumors?
40. Yes No AIDS, HIV, HEPATITIS
41. Yes No Tumors, cancer?
42. Yes No Arthritis, rheumatism?
43. Yes No Eye diseases?
44. Yes No Skin diseases?
45. Yes No Anemia?
46. Yes No VD (syphilis or gonorrhea)?
47. Yes No Herpes?
48. Yes No Kidney, bladder disease?
49. Yes No Thyroid, adrenal disease?
50. Yes No Sleep Apnea?
51. Yes No Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

52. Yes No Psychiatric care?
53. Yes No Radiation treatments?
54. Yes No Chemotherapy?
55. Yes No Prosthetic heart valve?
56. Yes No Artificial joint?
57. Yes No Hospitalization?
58. Yes No Blood transfusions?
59. Yes No Surgeries?
60. Yes No Pacemaker?
61. Yes No Contact lenses?

V. ARE YOU TAKING:

62. Yes No Recreational drugs?
63. Yes No Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?
64. Yes No Tobacco in any form?
65. Yes No Alcohol?

Please list medications:____

VI. WOMEN ONLY:

65. Yes No Are you or could you be pregnant or nursing?
67. Yes No Taking birth control pills?

VII. ALL PATIENTS:

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

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:___________________

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.

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 benefit and give you an **ESTIMATE** of the fee for service prior to your surgery. However, the estimate is not a guarantee until the claim is finalized with your insurance company and any remaining balance will be billed to you as your responsibility. Sometimes there is a COINSURANCE, DEDUCTIBLE or BALANCE DUE FOR NON-COVERED SERVICES after the claim is finalized regardless of what is told to our staff by the insurance company. ANY ESTIMATES ARE NOT A GUARANTEE.
- If your insurance company has not paid your claim within 90 days after submission, you may be required to pay for the services rendered. If a payment is received later from the insurance company, it will be credited to the account and refunded accordingly.

REFUNDS

- Any patient that is due a refund over $50 will have a reimbursement check written FOLLOWING the receipt of his/her 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.
- Refund checks are printed the 1st and 15th of each month and will be mailed to the guarantor on the account.

ADDITIONAL TERMS

- Surgery appointments that are canceled with less than 72 business hours 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 hours 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.

ESTIMATED fees are guaranteed for 45 days. If you are unsure of the fee for service, it is your responsibility to confirm the fee prior to the procedure with the front desk staff.

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

Patient Name: ____

Signature of Patient or Legal Guardian: _________________________________ Date:_________________________