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#:	**General Dentist:**
Single Married Other Female/Male	**Family Physician:**

Emergency Contact:____ **Telephone** ___________________

Primary Medical Insurance: **Policyholder's Name**: **Member ID #** **Grp#**	**Primary Dental Insurance:** **Policyholder's Name**: **Member ID#** **Grp#**
Policyholder's SS#:	**Policyholder's SS#:**
Policyholder's DOB:	**Policyholder's DOB:**
Employer:	**Employer**:

Secondary Medical Insurance: **Policyholder's Name**: **Member ID #** **Grp#**	**Secondary Dental Insurance:** **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

Acknowledgement of Financial Responsibility: I understand that reimbursement is expected for services rendered. Failure to provide compensation may result in termination of treatment, refusal of future treatment, action by a collection agency, or legal action. I further understand that I will be responsible for any legal and/or collection fees, should my account become delinquent.

SIGNATURE ____ DATE___________________

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 work place about your appointments. By signing below you give permission to call.

SIGNATURE ____ DATE___________________

First State
Oral & Maxillofacial Surgery

HEALTH HISTORY

Patient Name:______________________________________ Date Of Birth: _________________________

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)?	18.	Yes	No	Dizziness?
8.	Yes	No	Swollen ankles?	19.	Yes	No	Ringing in ears?
9.	Yes	No	Shortness of breath?	20.	Yes	No	Headaches?
10.	Yes	No	Recent weight loss, fever, night sweats?	21.	Yes	No	Fainting spells?
11.	Yes	No	Persistent cough, coughing up blood?	22.	Yes	No	Blurred vision?
12.	Yes	No	Bleeding problems, bruising easily?	23.	Yes	No	Seizures?
13.	Yes	No	Sinus problems?	24.	Yes	No	Excessive thirst?
14.	Yes	No	Difficulty swallowing?	25.	Yes	No	Frequent urination?
15.	Yes	No	Diarrhea, constipation, blood in stools?	26.	Yes	No	Dry mouth?
16.	Yes	No	Frequent vomiting, nausea?	27.	Yes	No	Jaundice?
17.	Yes	No	Difficulty urinating, blood in urine?	28.	Yes	No	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29.	Yes	No	Heart disease?	40.	Yes	No	AIDS, HIV
30.	Yes	No	Heart attack, heart defects?	41.	Yes	No	Tumors, cancer?
31.	Yes	No	Heart murmurs?	42.	Yes	No	Arthritis, rheumatism?
32.	Yes	No	Rheumatic fever?	43.	Yes	No	Eye diseases?
33.	Yes	No	Stroke, hardening of arteries?	44.	Yes	No	Skin diseases?
34.	Yes	No	High blood pressure?	45.	Yes	No	Anemia?
35.	Yes	No	Asthma, TB, emphysema, other lung diseases?	46.	Yes	No	VD (syphilis or gonorrhea)?
36.	Yes	No	Hepatitis, other liver disease?	47.	Yes	No	Herpes?
37.	Yes	No	Stomach problems, ulcers?	48.	Yes	No	Kidney, bladder disease?
38.	Yes	No	**Allergies to: foods ☐, medications ☐, latex ☐?**	49.	Yes	No	Thyroid, adrenal disease?
			Please list allergies:___________________________	50.	Yes	No	Sleep Apnea?
39.	Yes	No	Family history of diabetes, heart problems, tumors?	51.	Yes	No	Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

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

V. ARE YOU TAKING:

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

2. Patient's signature____ Date:_________________________

DOUGLAS DITTY, D.M.D., M.D & FRANKLIN X. PANCKO, D.D.S.
1004 S. State Street, Suite 1
Dover, DE 19901 · 302-674-4450

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 HIPPA 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**

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Relationship to Patient