



*DOUGLAS DITTY, D.M.D., M.D.*

*FRANKLIN X. PANCKO, D.D.S.*

<b>Patient Name:</b>	<b>Guarantor Name:</b>
<b>Address:</b>	<b>Address:</b>
<b>City:</b> <b>State:</b> <b>Zip:</b>	<b>City:</b> <b>State:</b> <b>Zip:</b>
<b>Home# :</b> <b>Work# :</b> <b>Cell# :</b> <b>Email:</b>	<b>Home# :</b> <b>Cell# :</b> <b>Email:</b> <b>Guarantor S.S. #</b>
<b>D.O.B.:</b> <b>SS#:</b>	<b>D.O.B.:</b>
<b>Single</b> <b>Married</b> <b>Other</b> <b>Female/Male</b>	<b>Emergency Contact:</b>
<b>Employer:</b>	<b>Telephone Number:</b>
<b>General Dentist:</b>	
<b>Family Physician:</b>	

**Primary Medical Insurance** \_\_\_\_\_

**Primary Dental Insurance** \_\_\_\_\_

**Secondary Medical Insurance** \_\_\_\_\_

**Secondary Dental Insurance** \_\_\_\_\_

<b>Primary Insured Information</b>	<b>Secondary Insured Information</b>
<b>Policyholder's Name:</b>	<b>Policyholder's Name:</b>
<b>Policyholder's SS#:</b>	<b>Policyholder's SS#:</b>
<b>Policyholder's DOB:</b>	<b>Policyholder's DOB:</b>
<b>Employer:</b>	<b>Employer:</b>

**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 \_\_\_\_\_

## 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?<br>If YES, why? _____                           |
| 4. | Yes | No | Are you being treated by a physician now? For what? _____<br>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 | <b>Allergies to: foods <input type="checkbox"/>, medications <input type="checkbox"/>, latex <input type="checkbox"/>?</b><br><b>Please list allergies:</b> _____ | 49.                         | Yes | No | Thyroid, adrenal disease?   |
| 39. | Yes | No | Family history of diabetes, heart problems, tumors?   | <b>50. Yes No Diabetes?</b> |     |    |                             |

**IV. DO YOU HAVE OR HAVE YOU HAD:**

- |     |     |    |                         |     |     |    |                     |
|-----|-----|----|-------------------------|-----|-----|----|---------------------|
| 51. | Yes | No | Psychiatric care?       | 56. | Yes | No | Hospitalization?    |
| 52. | Yes | No | Radiation treatments?   | 57. | Yes | No | Blood transfusions? |
| 53. | Yes | No | Chemotherapy?           | 58. | Yes | No | Surgeries?          |
| 54. | Yes | No | Prosthetic heart valve? | 59. | Yes | No | Pacemaker?          |
| 55. | Yes | No | Artificial joint?       | 60. | Yes | No | Contact lenses?     |

**V. ARE YOU TAKING:**

- |     |     |    |  |     |     |    |                      |
|-----|-----|----|--|-----|-----|----|----------------------|
| 61. | Yes | No | Recreational drugs?  | 63. | Yes | No | Tobacco in any form? |
| 62. | Yes | No | Drugs, medications, over-the-counter medicines<br>(including Aspirin), natural remedies? | 64. | Yes | No | Alcohol?             |

**Please list medications:** \_\_\_\_\_

**VI. WOMEN ONLY:**

- |     |     |    |  |     |     |    |                             |
|-----|-----|----|--|-----|-----|----|-----------------------------|
| 65. | Yes | No | Are you or could you be pregnant or nursing? | 66. | Yes | No | Taking birth control pills? |
|-----|-----|----|--|-----|-----|----|-----------------------------|

**VII. ALL PATIENTS:**

67. 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.  
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**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

\_\_\_\_\_  
Relationship to Patient