DAVID A. NOVER, M.D., P.C.

Patient Name:_____ Nickname: _____ DOB: _____

Patient Cell Phone:_____ Landline phone:_____

Other Phone: _____ Belongs to:_____

Courtesy reminder calls to: _____

Physical Home Address (Street, City, Zip):_____

Mailing address if different (e.g., POB):_____

Patient's SS#_____

Financial Responsible Party (if different): _____ Relationship:_____ SS#_____

Billing Address if different:_____

Referred by: _____Primary Care:_____ Physical Exam in past year? Y N

Current Medications (incl. OTC, vitamins and supplements):_____

Pharmacy: _____ Pharmacy Phone:_____ Mail Order Pharmacy:_____

Medication Allergies:_____

Medical Conditions: _____

Please read, then sign below (must be signed by patient 14 years or older):

Payment is expected at the time of service unless other arrangements have been made. A statement will be mailed from our office which may be submitted to insurance companies.

I agree to pay a fee for appointments missed or canceled with less than 24 hours' notice.
Please advise us as soon as possible if you will not be able to keep an appointment for any reason.

This authorizes the release of any medical or other information necessary to process my claims. It also authorizes payment of insurance or government benefits to David A. Nover, M.D., P.C.

I give permission for services to be delivered by telehealth when necessary.

I authorize the practice to access my Doylestown Hospital electronic medical record.

A copy of Notice of Privacy Practices is available at www.bucks-psychs.com

Patient Signature: _____ Date:_____ Responsible Party Signature:_____