PATIENT INFORMATION

We are pleased to welcome you to our office.
Nave Family Dentistry
613 Dutchmans Lane
Easton MD, 21601
410-822-7110

PERSONAL

Name_____
Last First MI (Preferred)
Birthdate_____ SS#_____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N
Work Phone_____ Wireless Phone_____ Home Phone_____
Email_____
Preferred contact method [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email
Preferred contact method for confirmations [ ] HmPhone [ ] WkPhone [ ] WirelessPh [ ] Email
How did you hear about us?
_____
(If someone referred you here, please write down their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family [ ]
Address_____
Address 2_____
City_____ State_____Zip_____
Home Phone_____

INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child
Subscriber Name_____ DOB_____
Subscriber ID # _____
Insurance Company _____Phone_____
Employer_____Group Name_____Group #_____
Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child
Subscriber Name_____Subscriber ID # _____
Insurance Company _____Phone_____
Employer_____Group Name_____Group #_____

Comments:

Jared I. Nave, D.D.S.
613 Dutchman's Lane
Easton MD 21601
(410)822-7710

Medical History

Indicate which of the following you have had or have at present.

☐ *Pre-Med	☐ Allergies	☐ Allergy - Aspirin	☐ Allergy - Codeine
☐ Allergy - Erythro	☐ Allergy - Latex	☐ Allergy - Other	☐ Allergy - Penicillin
☐ Allergy - Sulfa	☐ Anemia	☐ Arthritis	☐ Artificial Joints
☐ Asthma	☐ Blood Thinner	☐ Cancer	☐ Current Pregnancy
☐ Diabetes	☐ Dizziness/Fainting	☐ Epilepsy	☐ Excessive Bleeding
☐ Headaches	☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis
☐ High Blood Pressure	☐ HIV	☐ Hyperthyroidism	☐ Hypothyroidism
☐ Kidney Disease	☐ Liver Disease	☐ Nervous Disorder	☐ No Epi
☐ Pacemaker	☐ Psychiatric Disorder	☐ Radiation Treatment	☐ Respiratory Problems
☐ See Notes	☐ Sinus Problems	☐ Stroke	☐ Tuberculosis

If any conditions or alerts selected above needs further clarification, please describe below:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

List all medications, supplements, and/or vitamins taken within the last two years:

FINANCIAL AGREEMENT

* For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
* I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
* Patients or Responsible Parties are responsible for all fees incurred regardless of dental insurance. We do participate with a limited number of insurance companies. All copayments and deductibles are due at time of service. If you have insurance that we do not participate with, all payments are due at time of service. We will, as a courtesy, file your insurance claim.
* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
* I agree to pay finance charges of 1.5% per month (18% APR) minimum of $5.00, on any balance 90 days past due.
* I accept full responsibility for any legal or collection agency fees (currently 40%) should my account become delinquent.
* I will pay a fee for appointments broken without 24 hours notice.
* Treatment plans may change, and I will be responsible for the work actually done.
* I understand there may be a minimum charge of $50.00 for broken appointments without 24 hours notice.
*I authorize treatment by the doctor and supporting staff members.
* I grant permission to you, or your assignee, to telephone me at home or work to discuss matters related to this form or my treatment.

Signature_____ Date_____

NOTICE OF PRIVACY POLICIES

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

Signature_____ Date_____

MEDICAL HISTORY

Name of Medical Doctor:_____ City/State_____
Emergency Contact_____ Phone_____Relationship_____

List all the medications or drugs you are now taking:
[ ] None_____
_____
_____
_____
_____

List all the medications or drugs you are allergic to:
[ ] None_____
_____
_____
_____
_____

Tobacco use? If so, what kind and how much?_____
Unusual reaction to dental injections?_____
Reason for today's visit_____ Are you in pain? _____

New patients:
Do you have a Panoramic X-Ray or Full Mouth x-rays that is less than 5 years old? _____
Do you have BiteWing X-Ray's that are less than 1 year old?_____
Name of former dentist_____ City/State_____
Date of last cleaning and exam_____

Signature_____Date_____
If you need more space, you may continue below:

Nave Family Dentistry
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Easton, MD 21601

MEDICAL INFORMATION AUTHORIZATION

Patient Name_____ Date of Birth_____

I authorize the personnel of Nave Family Dentistry to release all dental information and discuss dental treatment to my family members, friends and physicians listed below.

I may revoke this authorization at any time in writing.

	Name	Relationship to patient	Phone Number
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			