FORM 1A

Patient Registration

Please print clearly. Items marked optional may be left blank.

Legal name (first / middle / last):	Preferred name:
Date of birth (MM/DD/YYYY):	Pronouns (optional):
Sex assigned at birth: ☐ Female ☐ Male ☐ Intersex ☐ Prefer not to answer	Gender identity (optional):
Street address:	Apartment / unit:
City / state / ZIP:	Mailing address if different:
Mobile phone:	Home / other phone:
Email:	Preferred language:
☐ Interpreter requested Language:	Preferred contact: ☐ Portal ☐ Phone ☐ Text ☐ Email ☐ Mail
Race (optional):	Ethnicity (optional):
Marital status (optional):	Occupation / employer (optional):

Emergency contact

Name:	Relationship:
Phone:	May we leave a message? ☐ Yes ☐ No
NOTE: An emergency contact is not automatically your health care decision-maker and is not automatically authorized to receive your medical information.	

Parent, guardian, or other legal representative (if applicable)

Name:	Relationship / legal authority:
Phone:	Address if different:

Bring or attach documentation of authority when required (for example, guardianship or health care power of attorney).

FORM 1B

Insurance, Pharmacy & Care Contacts

Insurance

Primary plan / payer:	Member / policy ID:
Group number:	Subscriber name:
Subscriber date of birth:	Patient relationship to subscriber:
Claims address / payer phone (if shown on card):	☐ Front and back of card copied
Secondary plan / payer (if any):	Member / policy ID:
Group number:	Subscriber name / DOB:

Responsible party for bills (if not the patient)

Name:	Relationship:
Address:	Phone / email:

Preferred pharmacy

Pharmacy name / location:	Phone:
Mail-order pharmacy (optional):	Phone / member ID if needed:

Current care team

Current / prior primary care clinician:	Phone / city:
Specialist and specialty:	Phone / city:
Specialist and specialty:	Phone / city:

People involved in my care

I permit the practice to discuss the categories checked below with the person named. This preference may be changed or withdrawn in writing at any time, except for information already shared in reliance on it.

Name / relationship:	Phone:
May discuss: ☐ Scheduling ☐ Billing ☐ Medications ☐ Test results ☐ General care	Expires: ☐ When revoked ☐ On:

This permission does not appoint the person as a legal representative or authorize that person to make treatment decisions.

FORM 2A

Medical History

Complete what you know. You may write “unsure” rather than guessing.

Patient name:	Date completed:
Main reason for today’s visit:	Last primary care visit / clinician:

Current or past conditions

Heart / circulation	☐ High BP ☐ High cholesterol ☐ Heart disease/attack ☐ Stroke/TIA ☐ Blood clot ☐ Other:	**Endocrine / blood**	☐ Diabetes ☐ Thyroid disease ☐ Anemia ☐ Bleeding disorder ☐ Other:
Lungs / sleep	☐ Asthma ☐ COPD ☐ Sleep apnea ☐ Tuberculosis ☐ Other:	**Brain / nerves**	☐ Seizure ☐ Migraine ☐ Neuropathy ☐ Memory concern ☐ Other:
Digestive / liver	☐ Reflux/ulcer ☐ Liver disease/hepatitis ☐ Gallbladder ☐ IBD/IBS ☐ Other:	**Kidney / urinary**	☐ Kidney disease/stones ☐ Recurrent UTI ☐ Prostate condition ☐ Other:
Bones / joints	☐ Arthritis ☐ Osteoporosis ☐ Chronic pain ☐ Gout ☐ Other:	**Mental health**	☐ Anxiety ☐ Depression ☐ Bipolar disorder ☐ PTSD ☐ Eating disorder ☐ Other:
Cancer / immune	☐ Cancer: ☐ Autoimmune condition ☐ Immune suppression ☐ Other:	**Infectious / skin**	☐ HIV ☐ Hepatitis ☐ Recurrent infection ☐ Serious skin condition ☐ Other:

Other important diagnoses or health concerns

Condition / approximate year:	Condition / approximate year:
Condition / approximate year:	Condition / approximate year:

FORM 2B

Medical History — Continued

Surgeries, hospital stays, and major procedures

Procedure / reason	Approx. year	Hospital / clinician	Complications or notes

Family history

List the relative(s) affected and age at diagnosis if known.

Heart disease / early heart attack:	Stroke / blood clot:
High blood pressure / cholesterol:	Diabetes:
Cancer (type / relative):	Mental health / substance use:

Health habits and daily life

Tobacco / nicotine	☐ Never ☐ Former ☐ Current Type / amount / years:
Alcohol	☐ None ☐ Occasional ☐ Weekly ☐ Daily Typical drinks/week:
Cannabis / other substances	☐ None ☐ Current ☐ Past ☐ Prefer not to answer Details relevant to care:
Activity	Days/week: Type: Limits:
Sleep	Hours/night: ☐ Rested ☐ Snoring ☐ Breathing pauses ☐ Trouble sleeping
Nutrition	☐ No concern ☐ Special diet ☐ Food insecurity concern Details:
Safety / access	☐ Feel safe at home ☐ Housing concern ☐ Transportation concern ☐ Fall concern ☐ Prefer not to answer

Preventive care and reproductive history (as applicable)

Last: ☐ Physical ☐ Dental ☐ Eye exam ☐ Colon screening	Vaccines due / requested:
Last: ☐ Mammogram ☐ Cervical screening ☐ Bone density	Pregnancy possibility / contraception / menopause notes (optional):

FORM 3

Medication & Allergy List

Include prescriptions, over-the-counter medicines, vitamins, supplements, injections, and as-needed medicines.

Patient name:	Date reviewed:

Medication allergies and other serious reactions

Medication / substance	Reaction (for example: rash, swelling, breathing problem)	Approx. year

☐ No known medication allergies

Current medications

Medication / strength	How much	How often / when	Reason	Prescriber

☐ I am not currently taking any medications or supplements

Medication safety

Have you had a medication side effect or problem? ☐ No ☐ Yes — explain:	Do you need refills today? ☐ No ☐ Yes — list:
Do cost, transportation, or another barrier make it hard to take medicines? ☐ No ☐ Yes:	Preferred pharmacy confirmed? ☐ Yes ☐ Update on Form 1B
NOTE: Bring medication bottles or an up-to-date pharmacy list when possible. Call 911 for a severe allergic reaction or other emergency.	

Patient initials: Clinician / staff reconciliation initials: Date:

FORM 4A

Core Consents & Privacy Acknowledgment

Read this page and the Financial & Attendance Policy on the next page before signing.

A. Consent to routine primary care

I voluntarily consent to evaluation and routine primary care by Nova Health Group and its licensed clinicians and staff. Routine care may include history and examination, vital signs, preventive care, medication management, diagnostic testing, specimen collection, vaccinations or injections, and minor office procedures within the clinician's scope. The clinician will explain material risks, benefits, and alternatives when a separate informed-consent discussion is appropriate.

I may ask questions, request a chaperone when available, refuse or stop a service, or withdraw this general consent prospectively. Refusing a recommended service may affect the practice's ability to provide safe care. No result is guaranteed. This general consent does not replace a service-specific consent for invasive, higher-risk, investigational, or elective services.

The practice is not an emergency department. For a medical or psychiatric emergency, call 911 or go to the nearest emergency department.

B. HIPAA Notice of Privacy Practices — acknowledgment of receipt

I acknowledge that I received or was offered Nova Health Group's Notice of Privacy Practices (NPP), effective/revision date: _____ by ☐ paper ☐ portal ☐ email ☐ website at: _____ The NPP explains how health information may be used and disclosed, my privacy rights, and how to ask questions or complain.

My signature acknowledges receipt only; it does not mean that I agree to any special use or disclosure. I may refuse to sign this acknowledgment, and that refusal will not prevent treatment or uses and disclosures otherwise permitted by law.

C. Communication choices

I authorize the practice to contact me using the choices below for care coordination, scheduling, billing, patient education, and other health care operations. Portal messages are preferred for sensitive clinical information. Standard email, text, and voicemail may not be fully secure and may be seen by others with access to my device or account.

Method	I agree	Okay to include
Patient portal	☐ Yes ☐ No	☐ Scheduling ☐ Billing ☐ Clinical information
Phone call	☐ Yes ☐ No	☐ Scheduling ☐ Billing ☐ Clinical information
Voicemail	☐ Yes ☐ No	☐ Callback only ☐ Nova Health Group ☐ Limited details
Text / SMS	☐ Yes ☐ No	☐ Scheduling ☐ Billing ☐ Limited care messages
Email	☐ Yes ☐ No	☐ Scheduling ☐ Billing ☐ Limited care messages
Postal mail	☐ Yes ☐ No	☐ Normal envelope ☐ Other restriction: _____

Text/email consent is optional and is not a condition of treatment. Message frequency varies; message/data rates may apply. I may change these preferences in writing or reply STOP to eligible automated texts. Electronic messages are not monitored continuously and must not be used for emergencies. This is not consent to marketing.

FORM 4B

Financial, Insurance & Attendance Policy

Insurance and payment

I will provide accurate insurance information and notify the practice of changes. As a courtesy, the practice may submit claims and help with reasonable claim questions, but verification is not a guarantee of coverage or payment. I am responsible for copayments, coinsurance, deductibles, noncovered services, services my plan deems not medically necessary, and balances allowed by law and my payer contract. Payment is due ☐ at service ☐ within ____ days of statement ☐ per written payment plan.

Services from outside laboratories, imaging centers, hospitals, pharmacies, or specialists may be billed separately. I should contact my insurer about network status, referrals, prior authorization, and benefits. The practice will follow applicable Medicare, Medicaid, payer-contract, surprise-billing, and state-law limits; this policy does not waive those protections.

Uninsured or self-pay patients may have a right to a written Good Faith Estimate of expected charges before scheduled care. Ask the practice for the required notice and estimate. A general financial-policy signature is not a waiver of any billing-dispute right.

Assignment of benefits and claims information

I assign to Nova Health Group, to the extent permitted by my plan and applicable law, payment of medical benefits for covered services provided to me. I authorize the practice to submit claims, appeals, and supporting information and to disclose the minimum information reasonably needed for payment and health care operations. I remain responsible for patient balances allowed by law. This assignment does not require an insurer to pay benefits, does not change the insurer's coverage rules, and may be revoked prospectively in writing where permitted, except to the extent the practice or payer has already relied on it.

Cancellations, late arrivals, and missed visits

Please cancel or reschedule at least ____ business hours before the appointment. Late-cancellation fee: ____ No-show fee: ____ The fee will not be charged when prohibited by law or contract and may be waived for emergencies or circumstances approved by the practice. Repeated missed visits may lead to scheduling limits or discharge from the practice after appropriate notice and continuity-of-care steps. Arriving more than ____ minutes late may require rescheduling.

Other billing terms

Returned-payment fee: ____ only if allowed by law. Reasonable collection costs may be added only if disclosed and legally permitted. The practice will provide an itemized statement on request and will apply credits or refunds according to law and payer rules. A card-on-file or recurring charge authorization, if used, must be presented separately and must identify amounts or calculation method, timing, and cancellation terms.

Acknowledgment and signature

By signing, I consent to routine primary care (Section A), acknowledge the NPP receipt request (Section B), select my communication choices (Section C), agree to this financial/attendance policy, and make the assignment of benefits above. I had an opportunity to ask questions and will receive a copy on request.

Patient/representative signature:	Date:
Printed name:	Relationship (if representative):

If NPP acknowledgment was not obtained — staff only: ☐ Patient declined ☐ Emergency ☐ Other: ____ Good-faith effort/date/staff initials: ____