



PATIENT DEMOGRAPHICS

Nuvia Health

Patient Information

Last Name:

First Name:

M.I.

Preferred Name

Date of Birth

Address:

City:

State:

Zip:

Contact Information

Phone:

Is this a mobile number? Yes No

Do you consent to receive text messages from Nuvia Health regarding appointments, care coordination, and practice-related communications at this number?

Yes No

Message and data rates may apply. You may opt out at any time by notifying the office.

Email Address:

Do you consent to receive non-urgent communications from Nuvia Health at this email address (e.g., scheduling, forms, general updates)?

Yes No

Gender & Identity

Sex Assigned at Birth:



Female Male Prefer not to answer

Pronouns (optional)

Preferred Language

Insurance — Primary

Carrier Name

Group Number

ID Number

Relationship to Subscriber

Subscriber Name (if not self)

Subscriber DOB

Subscriber Address (if not self): _____

Insurance — Secondary (if applicable)

Carrier Name

Group Number

ID Number

Relationship to Subscriber

Pharmacy

Pharmacy Name: _____

Pharmacy Address: _____

Do you authorize Nuvia Health to electronically send prescriptions?



Yes No

Emergency Contact

Name:

Phone:

Relationship to Patient:

This individual will only be contacted in the event of an emergency and is not authorized to receive medical information unless otherwise permitted by law.

Patient Signature

Date

By signing, I acknowledge the accuracy of the information provided above.