PATIENT REGISTRATION FORM

Name: (First, Last) ____

Date Of Birth: (MM/DD/YY) ________________ **Gender:** **M** **F**

Local Address: ____

Home Address (if different from above) ____

Email Address: ____________________________ **Mobile Phone:** ______________________

Trainer (if Applicable): ____

Promoter (if applicable):____

Gym Affiliation (if applicable): ____

Emergency Contact: Name: _________________________ Phone: _________________

How may we reach you for follow up? (circle all that apply) **My email** **My Phone** **My Assistant**

My Primary Doctor Name/Address: _______________________________________

Payment method: (circle one) **Cash** **Credit Card**

If Credit card, Name on Card:____

Billing Address:_______________________________________

16-digit number: _____________________________________

Security number (back of card): _____________

Acknowledgement of Receipt of Privacy Notice:

Federal Law requires that all patients be given a copy of the MMA Medical Privacy Notice. The Privacy Notice describes in detail how patient health information is used and shared with others. MMA Medical has reserved the right to change the Privacy Notice at any time. You may obtain a current copy of the Privacy Notice by going to the Web Site www.MMA-Medical.com
All Reasonable efforts will be made to protect the privacy of patient health information, whether it is maintained on paper or electronically, and regardless of how it is communicated, for example, by email or facsimile mail.

I have been given a copy of the MMA Medical Privacy Notice.

Name (print):____ **Date:**________________

Signature:____ **Date of Birth:**_______________

Authorization for Release of Medical Records:

I, **(print):** ____, authorize MMA Medical to ***release*** a copy of my health records to the person and/or entity I designate below:

Name/Entity: ______________________________________
Address:____
City: ____________________________
State: _________ Zip: ________ Telephone: __________________Fax: ___________

Name/Entity: ______________________________________
Address:____
City: ____________________________
State: _________ Zip: ________ Telephone: ___________________Fax: ___________

Name/Entity: ______________________________________
Address:____
City: ____________________________
State: _________ Zip: ________ Telephone: __________________Fax: ___________

This authorization shall remain in effect. I understand that I have the right to revoke this authorization in writing at any time by submitting such written notification to MMA Medical. I further understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information.

Name (print):____ **Date:**________________

Signature:____ **Date of Birth:**_______________