



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): _____



MMA Medical
Expedited clearance exams

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: _____