MOUNT NITTANY HEALTH
Fit for Play

PATIENT REGISTRATION FORMS

Patient Information

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (primary): _____ Phone (alternate): _____

Email: _____

* Parent / Guardian / Guarantor Name: _____

** Only if patient above is under 18 years of age or incapacitated*

Emergency Contact

Contact Name: _____ Relationship: _____

Emergency Phone Number: _____

Contacts with Access to Protected Health Information

(Please list your personal contacts that may have access to your protected health information.)

My emergency contact listed above may have access to my protected health information? ☐ YES ☐ NO

Contact Name: _____ Relationship: _____

Contact Name: _____ Relationship: _____

Insurance Information

Payment: I understand that I am responsible for reimbursement of services not covered by my inusurance. I authorize payment of my insurance benefits to Mount Nittany Physician Group (MNPG).

Privacy: I am aware that a copy of MNPG Notice of Privacy Practices is available upon request. I give permission for the person(s) designated above to access my protected health information (e.g. , obtain my test results, schedule, verify and cancel my appointments; discuss my healthcare with my physical therapist and his/her assistants).

Please acknowledge and agree to these terms by signing below.

X Patient Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

General Health

Height (feet / inches): _____ Weight (pounds): _____

Do you currently use tobacco? (please choose one) ☐ Yes ☐ No

Do you currently use alcohol? (please choose one) ☐ Yes ☐ No

Have you ever been diagnosed with depression or bi-polar disorder? (please choose one) ☐ Yes ☐ No

Please list any allergies you have: _____

Active Problems / Past Medical History

Do you currently have any of the following medical problems? Place X in ACTIVE problem column.
Have you had any of the following medical problems in the past? Place X in PAST problem column.

	Current Problem	Past Problem		Current Problem	Past Problem		Current Problem	Past Problem
Anxiety	☐	☐	Depression	☐	☐	High Blood Pressure	☐	☐
Asthma	☐	☐	Diabetes	☐	☐	Pacemaker	☐	☐
Atrial Fibrillation	☐	☐	Migraine Headaches	☐	☐	Seizure	☐	☐
Cancer _____	☐	☐	Hearing Difficulty	☐	☐	Stroke(s)	☐	☐
COPD	☐	☐	Heart Attack	☐	☐	Vision Problem	☐	☐
Congestive Heart Failure	☐	☐	History of Blood Clots	☐	☐	Neurological Condition (s) _____	☐	☐
Coronary Artery Disease (CAD)	☐	☐	High Cholesterol	☐	☐			

Please list all medications you take (use back of this paper if needed)

☐ I'm not taking any medications at this time.

Medication Name	Dosage (Typically Mg)	Frequency / Times per Day	How Taken (Example: Orally)

Previous surgeries (use back of this paper if needed)

Surgery	Year

THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE

X

Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

Appointment Reminders

Please remind me of upcoming appointments via: ☐ Phone call ☐ Text message ☐ No reminders

Other Communication Preferences

Please feel free to contact me about appointments I have via: ☐ Email ☐ Text ☐ Both

☐ Use email listed above Email: _____

☐ Use phone listed above Phone for text: _____