MOUNT NITTANY
HEALTH

Fitness and Rehabilitation
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: ______________

MOUNT NITTANY HEALTH

Fitness and Rehabilitation

PATIENT REGISTRATION FORMS

Patient Name: ______________________ Date of Birth: ______________________

Medical History

If you currently feel or have felt any of the following symptoms within the past month or if you have been diagnosed with any of the following conditions, please check the appropriate boxes. This is a screening tool that can help your therapist determine which diagnostic tests might be appropriate for you.
Please check all that apply:

Condition	☐	Condition	☐	Condition	☐
Low back and radiating pain	☐	Diabetes or neuropathy	☐	Blurred vision	☐
Neck and radiating pain	☐	Thyroid dysfunction	☐	Hearing problems	☐
Numbness, tingling, or burning sensation in the legs or feet	☐	Tendonitis/Arthritis/Bursitis	☐	Dizziness or vertigo	☐
Numbness, tingling, or burning sensation in the arms or hands	☐	Shoulder pain or instability	☐	Headaches	☐
	☐	Elbow pain or instability	☐	Unsteady gait	☐
Weakness in the legs or arms	☐	Wrist/hand pain or instability	☐	Hypertension	☐
Loss of sensation in hands and / or feet	☐	Hip or knee pain or instability	☐	Hypotension	☐
Muscle disease / muscle cramping	☐	Ankle/foot pain or instability	☐	History of falls due to dizziness	☐
Anything else you consider important:				Daily alcohol 3 drinks or more	☐

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: ______________________