PTR SPORTS
REGISTRATION FORM
(Please Print)

PATIENT INFORMATION

Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security No:	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		City:	State:	Zip:		
Home Phone:	Mobile Phone:	Work Phone:	E Mail Address:			
Responsible party:	Address:		Responsible party DOB:			

Do you have other family members seen here? ❑ Yes ❑ No

If yes, would you like to be set up for family billing (one statement for the entire family?) ❑ Yes ❑ No

Employer:	Occupation:	Employer Phone and Ext:

Chose clinic or referred to clinic by (please circle all that apply):

Doctor / Hospital / Family / Friend / Insurance Plan / Advertisement / Internet / Yelp / Other:

INSURANCE INFORMATION

Primary insurance:			ID / Subscriber #	
Subscriber's name:	Subscriber's SSN:	Birth date: / /	Subscriber Sex: ❑ M ❑ F	Group/Policy #
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other:
Is this person a patient here? ❑ Yes ❑ No	Employer:		Occupation:	
Secondary insurance (If applicable) :			ID / Subscriber #	
Subscriber's name:	Subscriber's SSN:	Birth date: / /	Subscriber Sex: ❑ M ❑ F	Group/Policy #
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other:

IN CASE OF EMERGENCY

Name of friend or relative	Relationship to patient:	Home phone :	Work or cell phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize PTR Sports or my insurance company to release any information required to process my claims.

Patient/Guardian signature ***Date***

Patient Health History

Name: (please print)_____ Date: _____

Past Medical History: Circle any previous medical problems you have had. Use the notes section below to elaborate, such as diagnosis date and current status.

HIV or AIDS	bleeding disorder	heart murmur	hernia
tuberculosis	alcoholism	high blood pressure	irritable bowel syndrome
breast cancer	anxiety disorder	previous heart attack	stomach ulcer
colon cancer	attention deficit disorder	pulmonary embolism	ulcerative colitis
lung cancer	depression	stroke	chronic kidney failure
other cancer	eating disorder	allergies	kidney stones
prostate cancer	insomnia	asthma	acne
skin cancer	migraine headaches	chronic lung disease (COPD)	eczema
diabetes	multiple sclerosis	chronic liver disease	psoriasis
gout	seizures	Crohn's disease	osteoarthritis
high cholesterol	sleep apnea	diverticulitis	osteoporosis
hyperthyroidism	tension headaches	GERD/reflux	rheumatoid arthritis
hypothyroidism	atrial fibrillation	hemorrhoids	has pacemaker
obesity	blood clots	hepatitis B	joint replacement
anemia	coronary artery disease	hepatitis C	other organ replacement

Notes:_____
_____
_____
_____

Surgical History

Procedure	Date	Notes

Medications & Supplements

Medication	Directions	Start Date	Notes

Allergies/Adverse reactions

Drug/Allergen	Reaction	Notes

Patient Health History

Name: (please print)_____ Date: _____

Social History

What do you do for exercise? _____

How many alcoholic drinks do you have each week (average)? _____

How much do you smoke each day (average)? _____

How much have you smoked in the past? _____

What recreational drugs do you use? _____

Family History

List all medical problems such as heart disease, diabetes, etc. If no problem, write "healthy"

Relation	Problem	Onset Age	Died at Age	Notes
Father				
Mother				
Brother				
Sister				

Vaccines

When was your last Tetanus vaccine? _____

Have you completed the Hepatitis B series of 3 vaccinations over 6 months? Yes___No___Not sure____

Have you completed the Hepatitis A series of 2 vaccinations over 6-12 months? Yes___No___Not sure____

Other Providers (list other providers you currently see)

Name	Specialty	What do you see them for?

Pharmacies (where you want us to send prescriptions for you)

I authorize PTR Sports to access my previous medication history via pharmacy/insurance databases: Yes_____No_____

Name	Location	Notes

Gynecology (women only)

Date of last menstrual period? _____

Frequency of periods: _____

Current birth control method: _____

Age of first period: _____

If menopausal, age of menopause: _____

PTR SPORTS FINANCIAL POLICIES & CONSENTS

Patient Name: _____ Date: _____

PATIENT RESPONSIBILITIES

- Ensure my contact and account information is accurate and up-to-date
- Provide accurate insurance information for each visit and inform us who should be billed for the current visit: private insurance, workers compensation, third-party accident, or self-pay
- Pay all co-payments and balances *prior* to each visit
- Provide us with at least 24-hour notice if you would like to change or cancel an appointment
- Understand my insurance benefits and coverages as it pertains to PTR Sports and its providers (we will do our best to inform you of your insurance coverage but ultimately you are responsible for any fees not paid by your insurance carrier)
- Know that in order to provide you with the best possible care, we require follow-up visits (even though it may not be reimbursed by your insurance) to personally review all labs, tests, and other complex problems

OFFICE FEES

- Failure to pay co-payment on day of visit: $25.00
- Completion of prior authorization forms, other patient forms, and letters: $20.00
- Resubmission of insurance claims (per claim): $20.00
- No-show or appointment cancellation within 24-hours: $50.00
- Accounts that are sent to collections: $75.00
- Patient medical records: Copy on a CD: $25.00; paper $20.00 clerical fee plus $0.25 per page
- These fees may change from time to time - please see our website for the most up-to-date fees

ASSIGNMENT OF BENEFITS: I authorize my insurance company to pay all benefits directly to PTR Sports.

CONSENT TO CALL/TEXT: I consent to receive calls/text from PTR Sports for my protected healthcare and other services at the phone number(s) on my patient registration form, including my wireless number provided. I understand that such calls/text may be generated by an automated dialing system.

CONSENT TO KEEP CREDIT CARD ON FILE: I consent to having PTR Sports keep a credit card on file for resolution of all balances and credits on my account.

CONSENT TO OBTAIN MEDICATION HISTORY: I consent to having PTR Sports request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

ACKNOWLEDGEMENT OF OFFER OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge I was offered a copy of the "Notice of Privacy Practices" of PTR Sports, describing my right to privacy of my protected health information (PHI) under the Federal HIPAA Privacy Law, as follows:

- How my PHI may be used and disclosed,
- My privacy rights regarding my PHI,
- The medical practice's obligations concerning the use and disclosure of my PHI.

Signed (Patient or Parent/Guardian): _____ Date: _____