Patient Registration Form

Account #	Date:	Primary Physician Name:		
Patient's First Name	Middle Name	Last	Birthdate	Age
Address	City	State	Zip Code	
Social Security #	Home Phone #	Mobile Phone #	Marital Status	Sex
Employer's Name	Work or Business Phone #			
Email Address	How Were You Referred?			
Pharmacy Of Choice	Pharmacy Phone #			
Emergency Contact (Not Within The Same Household)				
Name	Emergency Phone #	Relationship To Patient		

Consent For Healthcare Messages

I_____ give permission to the physicians and their staff at TN Regenerative Sports
(please print patient name) Medicine to leave messages regarding my healthcare in the following manner when I am not available:

____May **ONLY** leave information with me. **(If you check here, no other choices should be marked, skip to Contact Information)**

(Please mark all that apply – If you checked the box above then these should be blank)
____May leave appointment reminders on my answering machine/voicemail.
____May leave lab results on my answering machine/voicemail.
____May leave general questions/information on my answering machine/voicemail.

If any are checked below, please list the name of the individual we may give information to:
____May leave appointment reminders to be given to the following person.
____May leave lab results to be given to the following person.
____May leave general questions/information to be given to the following person.

Name:_____ Relationship:_____

Patient Signature:_____ Date:_____

Witness Signature: _____ Date: _____

For Office Use Only

Patient Name:	**DOB:**
Referred by:	**Phone:**
Address:	**Fax:**

I, the undersigned, am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize medical care and treatment by TRSM, through its individual physicians, employees, and/or agents. This care and treatment encompasses all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician and provided by TRSM.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations performed by the physician or TRSM.

I acknowledge that I have received a copy of TRSM's Notice of Privacy Practices and I understand that the notice is also posted at each location where services are provided and on the internet at www.trsportsmedicine.com. I consent to be called on my cell phone concerning healthcare services rendered to me.

To protect against the transmission of blood-borne diseases such as Hepatitis B and Acquired Immune Deficiency Syndrome, I understand that it may be necessary to test my blood for certain diseases while I am a patient of TRSM. I understand and consent that my blood, as well as the blood of any person accidentally exposed to my blood, will be tested. I further understand that my blood will not be tested for these diseases unless ordered by my physician and that the results of all tests will be kept confidential.

I have read this form, or had it read to me, and I certify that I fully understand and accept its contents unless noted.

_____	_____	_____
Patient's Signature	Patient's Name (Printed)	Witness

Patient, _____, is a minor, or is unable to sign above because:

_____.
(Name Printed)

_____	_____	_____
Person Giving Consent	Relation to Patient	Witness