exer URGENT CARE

Temp	

SPORTS PHYSICAL PATIENT REGISTRATION

Date of Birth ____/____/_____ SS# _____-____-_____ Sex: M F

Patient Name: _____

Parent or Representative: _____ Phone: _____

Relationship: _____

Reason for your visit today: ☐ Sport Physical

Do you have any of the following symptoms of COVID-19? ☐ **Yes** ☐ **No**
Fever, Chills, Body Aches, Cough, Congestion, Sore Throat, Shortness of Breath, Nausea, Diarrhea, Vomiting, Loss of smell or taste.

Have you or anyone in your household tested positive for COVID-19 in the last 14 days? ☐ **Yes** ☐ **No**

Section 1: ☐ Please check this box if nothing has changed and proceed to Section 2

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Work Phone: (_____) _____ - _____ Email Address: _____

Primary Care Doctor: _____ Phone: _____
☐ Do not fax records to my doctor

PATIENT FORM SIGNATURE ACKNOWLEDGMENT

Exer's Office Policies and Medical Consent, Financial Policies, Advanced Patient Notice for Send Out Laboratory Tests, and Arbitration Agreement are available at https://exerurgentcare.com/officepolicies/.
I acknowledge that I have read each of them, been given the opportunity to ask questions, and my questions have been answered satisfactorily.

Date: _____ X_____
Patient or Representative Signature

Please review our Notice of Privacy Practices at https://exerurgentcare.com/privacy-policy-and-practices/.
The Notice describes in detail how we might use or disclose your protected health information and discusses your rights and our duties with respect to your protected health information. A paper copy of this
notice will be provided upon request. By signing this form, you acknowledge you have received this Notice.

Date: _____ X_____
Patient or Representative Signature