MULLALLY
SPORTS & FAMILY MEDICINE

Mullally Sports and Family Medicine

Patient Registration

Patient Name:	**Preferred Name:**
Billing Address:	
City:	**State:** **Zip Code:**
Date Of Birth: / /	**Male or Female** (circle) **Language Spoken:** English Spanish Other
Social Security # (for hospital medical records lookup and Medicare): _____ _____ _____ - _____ _____ - _____ _____ _____ _____	
Home Phone: (_____) - _____ - _____	**Preferred Number:** Y or N **Can we leave a detailed voicemail?** Y or N
Cell Phone: (_____) - _____ - _____	**Preferred Number:** Y or N **Can we leave a detailed voicemail?** Y or N
Are we able to text you results, respond to questions, or send information to the above cell phone number? Y or N	
Portal Consent- to send messages to you? (IE: general test results or respond to your messages): Y or N	

Email:

Marital Status: Single Married Divorced Widowed Partner **(circle one)**
Race: White Black Asian Hispanic/Latino American Indian other: _____ Decline **(circle one)**
Ethnicity: Hispanic/Latino Non-Hispanic/Latino Decline **(circle one)**

Employment Information:

Retired Student Unemployed **(circle one)**
Employer Name: _____ **Phone #:** (_____) - _____ - _____

Insurance Information: *Did you give your insurance card to be scanned in for the year? Yes OR No (circle)*

Primary Insurance Name:	**Guarantor Name and DOB:**
2nd-ary Insurance Name (if you have a secondary):	**Guarantor Name and DOB:**

You are responsible to know and provide an updated insurance card if any changes are made in the middle of the year. We require an updated scan of insurance card once yearly even though there might not be any information changes.

Emergency Contact: *Please pick someone that is out of your household if possible*

Name: _____ **Relationship:** _____

Phone number: _____

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Authorization For Release Of Information

Patient Name: _____

Indiana Sports and Medical Science Institute, PC is authorized to release protected health information (PHI) about the above named patient to the entities named below. The purpose is to give ISMSI permission, by patient, to give personal information of the patient to the stated people below.

If you are 18 years of age or older you must give us permission below to give parents, or other specified entities the right to request and receive medical and personal information. Anyone under age of 18, information is legally allowed to be given to parents without permission unless other circumstances arise and are documented.

I, _____, hereby give permission for ISMSI to release ***any and all information*** to the following entities listed below:

You do not need to fill all 3 entities if you do not want to. You do not have to give permission for anyone to request and receive information either

Name: _____ **Relationship:** _____

Other note: _____ **Phone:** _____

Name: _____ **Relationship:** _____

Other note: _____ **Phone:** _____

Name: _____ **Relationship:** _____

Other note: _____ **Phone:** _____

*If any of the entities listed above are **NOT** to receive **all** information please make note as to what specific information we **are** able to release to them.*

I have been informed of and given the right to review and/or secure a copy of the following:

Please initial or check mark each line

_____ Patient Consent for Treatment

_____ Authorization for Release of Information

_____ HIPAA Consent

_____ Office Financial Policy

_____ Notice of Privacy Practice

X _____ **Date:** _____

Signature of Patient or Responsible Party

X _____

Print Name of Patient or Responsible Party

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Consent For Treatment Of Minors

(For anyone under the age of 18 please fill out)

Patient Name: _____

I hereby give my permission to the physicians and personnel of Indiana Sports and Medical Science Institute, PC to assess and treat the health needs of the patient named above. This permission includes authorization for completion of appointments, outpatient diagnostic procedures, and diagnostic imaging as ordered by the physicians.

For treatment of Minors <18 years old

I understand that I should make every effort to accompany my child to appointments.

If I am unable to come to an appointment, I give permission for Indiana Sports and Medical Science, PC physicians as follows:

***MARK ALL THAT APPLY BY INITIALING ON THE LINES:**

_____ **I WILL ONLY ALLOW** for the following named adults to accompany my child to consent for assessment and treatment:

- Name: _____ Relationship to child: _____
- Name: _____ Relationship to child: _____
- Name: _____ Relationship to child: _____

_____ **I DO NOT** wish to allow another caretaker who brings my child to ISMSI to sign for treatment.

_____ I understand that my child may not be seen if he/she arrives with a caregiver that does not fit the above chosen guidelines unless verbally told over the phone differently for this circumstance.

_____ My child is of age to drive to his/her appointment and I give consent for the physicians to assess and treat as necessary even if I am not with.

_____ I understand that written permission signed by me will always be acceptable as consent for assessment and treatment.

Patient Name: _____

Parent/Legal Guardian Signature: _____

Date: _____

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***For patients 12 years and older, please fill out.** This is a requirement by insurance and the office at least once yearly. We are keeping up with mental health along with physical health. This does not mean that you have depression or that we think you have depression.*

Patient Name: _____ **Date:** _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____