

PATIENT REGISTRATION FORM



(866) 707 - OMNI (66 64)

• www.OmniFamilyHealth.org

First Name:	Middle Name:	Last Name:	Date of birth: / /
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Mailing Address: (include suite, apt, etc.)	City	State	Zip Code
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Physical Address: (if different)	City	State	Zip Code
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Home Phone: () -	For the purposes of sending you healthcare reminders and information about your healthcare, I agree to receiving: Telephone calls <input type="checkbox"/> Y <input type="checkbox"/> N Text messages <input type="checkbox"/> Y <input type="checkbox"/> N Mail correspondence <input type="checkbox"/> Y <input type="checkbox"/> N
Cellular Phone: () -	

May we contact you by e-mail? <input type="checkbox"/> Y <input type="checkbox"/> N e-mail address:	Which language are you most comfortable using? English Spanish Other: _____
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Marital Status:) Domestic Partner Legally Separated Married Single Widow	Birth Sex: Female Male Prefer not to answer Current Gender: Female Male Neither exclusively masculine nor feminine (Non-binary)	Gender Identity: Female Female-to-Male(FTM)/ Transgender Male Male Male-to-Female (MTF)/ Transgender Female Prefer not to answer	Sexual Orientation: Bi-sexual Homosexual Heterosexual Prefer not to answer	Preferred Pronoun: He/Him/His She/Her/Hers/They Them/Theirs Other: _____ Prefer not to answer
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Race: White African-American/Black Native American or Alaska Native Asian Native Hawaiian/Pacific Islander Other: _____	Ethnicity: Latino/Hispanic Non-Latino Hispanic	Homeless: In Transition Lives in the streets Doubling up Not Homeless	Are you a Veteran of the US Military: Yes No
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I/patient's representative Decline Consent the right in submitting an application for the sliding scale fee discount

Family Size: How many people are in your family? _____ **Yearly Income:** _____ **Refuse to Provide (patient's Initials):** _____

What type of Health Insurance do you have? Private Insurance: _____ Medi-Cal: _____ Medicare: _____ No Insurance: _____

How did you hear about us? Friends/family member: _____ Television: _____ Radio: _____ Referral: _____ Social Media: _____ Bus: _____ Mailer: _____ On-line Ad: _____

Experience with Agriculture/ Farm work: (planting, picking, preparing the soil, packing house, dairy, driving a truck for any type of farm work) 1. In the last two years, have you or anyone in your family, worked in any type of agriculture farm work? Yes No 2. In the past two years, have you or a member of your family moved to another area and lived away from home in order to work in any type of agricultural work? Yes No 3. Have you or a member of your family stopped migrating to work in agriculture (farm work) because of a disability or age? Yes No 4. Are you seeking employment in agriculture? Yes No	Office use: Yes- #1, #4 "Seasonal" Yes- #2, #3 "Migrant"
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Whom may we contact in case of an emergency?
Name: _____ Relationship: _____ Telephone number: _____

Responsible Person (Parent or Legal Guardian signing this form):
First Name: _____ Last Name: _____ DOB: _____
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
Contact Telephone Number: _____ Relationship to Patient: _____

AUTHORIZATION AND CONSENT (Please Initial):	<p><input type="checkbox"/> I/patient's representative consent I am presenting at Omni Family Health for examination, diagnosis, and /or treatment of my health, medical, or dental condition.</p> <p>I understand I am financially responsible for all charges rendered for services to my dependents or me as my insurance carrier may pay less than the actual bill: this includes the remaining balance after payment of insurance benefits, deductible, and co-payments.</p> <p><input type="checkbox"/> I/patient's representative authorize the release of medical information to other entities in order to resolve the claim. (Refer to Notice of Privacy)</p> <p>Signature of Patient/Guardian: _____ Date: _____</p>
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Office Use Only After patient registration form is completed, Front Office Clerk shall enter information in patient's electronic health record and scan form into the correct patient chart.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT CONSENT FOR USE AND DISCLOSURE FOR TREATMENT, PAYMENT & HEALTHCARE OPERATION



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Patient name: _____ DOB: _____

Section A: Consent for Treatment, Payment and Health Care Operations

I hereby consent for the use or disclosure of my individually identifiable health information to carry out treatment, payment or health care operations this includes assignment of benefits.

I consent to examinations, treatments, procedures and blood tests ordered by my physician and health care providers, including blood tests for communicable diseases such as hepatitis and HIV/AIDS.

This consent is authorized for the following health care provider (s):

Omni Family Health- Doctors, Nurse Practitioners, Physician Assistants, and medical staff

- I understand I have the right to review this office's Notice of Privacy Policies as displayed in the waiting room.
- I have received a copy, and read the Notice of Privacy Policies posted in this office and understand its meaning.
- I understand I have the right to request this provider restrict how protected health information is used or disclosed to carry out treatment, payment or healthcare operations. In addition, that the provider is not required to agree to the requested restrictions.
- I understand that state law requires the reporting of certain positive results such as hepatitis and the antibody for the AIDS virus to the health department.
- I have the right to revoke the consent in writing except to the extent the provider has taken action prior to the revocation.
- I understand this authorization is voluntary.

List Requested Restrictions

Approved/Denied by Provider

Specific description of information (including date (s)): _____

Signature of patient or patients' representative: _____ Date _____

Printed name of patient or patients' representative: _____ Relationship: _____

Section B: Authorization to Share Protected Health Information

In order to disclose or discuss any personal health information to your family or designee, we must have a signed consent on file allowing Omni Family Health to share information about your care at our office with your family member or designee. Please list the names of those you would like to be involved in your health care. This information can be changed or revoked at any time with your permission.

Patient Name: _____ MRN: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize Omni Family Health to share information related to my health status to the individual(s) listed above.

I understand this might include information such as: diagnosis, prognosis, and treatment plans, medications, test results, appointment reminders, medical billing, insurance and any other medical information relevant to my care.

I decline to have my medical information shared with family or designee.

Patient signature: _____ Date: _____

ADVANCE DIRECTIVES ACKNOWLEDGMENT



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In accordance with the Patient Self-Determination Act, patients over 18 years of age are to be provided with information regarding Advance Directives. The following procedure will be used as a means of making this information available to patients of Omni Family Health.

Would you be interested in receiving information on Advance Directives? Yes No

It is the policy of Omni Family Health, to NOT honor a "No Code" request, also known as Do Not Resuscitate (DNR). Anesthetic agents and/or medications have the potential for causing a cardiac or respiratory arrest. Omni Family Health (OFH) shall implement resuscitative efforts on any patient experiencing a life- threatening event while receiving care at any Omni Family Health center. In the event there is a complication, you will be transferred to the hospital and the hospital's policy on Advance Directives will be followed. Questions about this policy may be directed to the attending provider.

I have received all information provided to me on Advance Directives.

Patient name

Date of birth

Patient signature

Date

Representative of patient

Representative signature



As one of our patients, you have choices, rights, and responsibilities.

You have the right to:

- Be treated with dignity and respect
- Know the names of the people serving you
- Have privacy and confidentiality of your records
- Receive explanations
- Receive education and counseling
- Review your medical records with a clinician
- Consent to or refuse any care or treatment
- Involvement in own treatment plan
- Obtain care from other clinicians within the primary care medical home:
 - ✓ Seek second opinion
 - ✓ Seek specialty care
- Select primary care provider of choice

Family planning patients also have the right to:

- Decide whether or not to have children and when
- Know the effectiveness, possible side effects and problems of all methods of birth control
- Participate in choosing a birth control method

You also have the responsibility to:

- Respect clinic policies
- Report any changes in your health
- Keep appointments or cancel at least 24 hours in advance
- Participate in self-management of your health goals
- Be honest about your medical history, and medication
- Be sure you understand who is in your care team
- Follow health advice and medical instructions

If you have any suggestions, compliments or complaints please let us know.

SLIDING FEE DISCOUNT APPLICATION FORM



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PATIENT INFORMATION SECTION I

Name: _____ Date: _____
(First) (Middle) (Last)

Social Security Number: _____ Date of Birth: _____

Marital Status: Single Married Divorced Widow

Spouses Name: _____

Patient Name: _____ Applicant Relationship to Patient: _____

HOUSEHOLD INFORMATION SECTION II

Household Earnings Information:

Please list everyone living in your home (including yourself). Include anyone at least 18 years of age or older who reside in the household and contribute to the basic living expenses of the household (including yourself). Income includes gross (pre-tax) wages, child support income, alimony income, rental income, unemployment compensation, social security benefits, public/government assistance, pensions and/or IRA distribution income or other retirement income, etc. DO NOT include non-cash assistance such as food stamps, housing allowance, or other government subsidies. In order to be considered a household member, the person must be listed below. Adults (except for your Spouse) listed below with zero income must provide required documentation.

Name (First and Last)	Age	Source of Income or Employer Name	Monthly Income

Please include income documentation for each ADULT listed above.

Total # of adults (18 years of age and older): _____

Total estimated gross annual income: \$ _____

Total # of children (under the age of 18): _____

Total # of household members: _____

Witnessed by OFH staff: _____

SLIDING FEE DISCOUNT APPLICATION FORM



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HOUSEHOLD INFORMATION SECTION II (continued)

Household Earnings Information:

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee discount program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Omni Family Health if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Omni Family Health. I hereby acknowledge that I read the foregoing disclosure and understand it.

I consent to the release of any and all of my financial records including but not limited to: sliding fee scale application and supporting documentation, patient information, insurance information, and any other types of information contained within my electronic health and/or dental records that may be deemed necessary for review by any auditor, for participating in any assistance programs including but not limited to sliding fee scale, grant-funded programs and/or pharmacy assistance programs for which I may be eligible.

Date: _____

Name (Print): _____

Signature: _____

Witnessed by OFH staff: _____

Staying Healthy Assessment

7 – 12 Months

Child's Name (first & last)	Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	Today's Date	In Child/Day Care? <input type="checkbox"/> Yes <input type="checkbox"/> No
Person Completing Form	<input type="checkbox"/> Parent <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Guardian <input type="checkbox"/> Other (Specify)			Need Help with Form? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter?
 Yes No

Clinic Use Only:

1	Do you breastfeed your baby?	Yes	No	Skip	Nutrition
2	Does your baby drink or eat 3 servings of calcium-rich foods daily, such as formula, breast milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Physical Activity
3	Are you concerned about your baby's weight?	No	Yes	Skip	Physical Activity
4	Does your baby watch any TV?	No	Yes	Skip	Physical Activity
5	Does your home have a working smoke detector?	Yes	No	Skip	Safety
6	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	Safety
7	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip	Safety
8	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip	Safety
9	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	Safety
10	Do you always put your baby to sleep on her/his back?	Yes	No	Skip	Safety

11	Do you always stay with your baby when she/he is in the bathtub?	Yes	No	Skip	
12	Do you always place your baby in a rear facing car seat in the back seat?	Yes	No	Skip	
13	Is the car seat you use the right one for the age and size of your baby?	Yes	No	Skip	
14	Does your baby spend time near a swimming pool, river, or lake?	No	Yes	Skip	
15	Does your baby spend time in a home where a gun is kept?	No	Yes	Skip	
16	Do you give your baby a bottle with anything except formula, breast milk, or water?	No	Yes	Skip	Dental Health
17	Does your baby spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
18	Do you have any other questions or concerns about your baby's health, development or behavior?	No	Yes	Skip	Other Questions

If yes, please describe:

<i>Clinic Use Only</i>	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Tobacco Exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/> Patient Declined the SHA
PCP's Signature:		Print Name:			Date: