PATIENT REGISTRATION FORM

(866) 707 - OMNI (66 64) • www.OmniFamilyHealth.org

Omni Family Health

First Name:	**Middle Name**:	**Last Name**:	**Date of birth**: / /

Mailing Address: (include suite, apt, etc.) **City** **State** **Zip Code**

Physical Address: (if different) **City** **State** **Zip Code**

Home Phone: ( ) -
Cellular Phone: ( ) -

For the purposes of sending you healthcare reminders and information about your healthcare, I agree to receiving: Telephone calls ○ Y ○ N Text messages ○ Y ○ N Mail correspondence ○ Y ○ N

May we contact you by e-mail? ○ Y ○ N
e-mail address:

Which language are you most comfortable using?
○ English ○ Spanish ○ Other: _____

Marital Status:
- ○ 5\Ø2\\ÔŠŘ
- ○ Domestic Partner
- ○ Legally Seperated
- ○ 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

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

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"

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):

☐ 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.

☐ 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.

☐ I/patient's representative authorize the release of medical information to other entities in order to resolve the claim. (Refer to Notice of Privacy)

Signature of Patient/Guardian: _____ **Date**: _____

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

(866) 707-OMNI (66 64) • www.OmniFamilyHealth.org

Omni Family Health

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

(866) 707-OMNI (6664) • www.OmniFamilyHealth.org

Omni Family Health

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

PATIENT RIGHTS AND RESPONSIBILITIES

(866) 707-OMNI (66 64) • www.OmniFamilyHealth.org

Omni Family Health

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 of 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

(866) 707-OMNI (6664) • www.OmniFamilyHealth.org

Omni Family Health

PATIENT INFORMATION
SECTION 1

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: _____

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: _____

Welcome to Omni Family Health!

Name: _____ Date: _____

GAD - 7				
Over the last 2 weeks, how often have you been bothered by the following problems? (Use "✓" to indicate your answer)	Not at all	Several days	More than half the days	Nearly early every day
1. Feeling nervous, anxious or on edge	0 ☐	1 ☐	2 ☐	3 ☐
2. Not being able to stop or control worrying	0 ☐	1 ☐	2 ☐	3 ☐
3. Worrying too much about different things	0 ☐	1 ☐	2 ☐	3 ☐
4. Trouble relaxing	0 ☐	1 ☐	2 ☐	3 ☐
5. Being so restless that is hard to sit still	0 ☐	1 ☐	2 ☐	3 ☐
6. Becoming easily annoyed or irritable	0 ☐	1 ☐	2 ☐	3 ☐
7. Feeling afraid as if something awful might happen	0 ☐	1 ☐	2 ☐	3 ☐
Total Score = _____ (Add the score for each column)				
Scoring Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.				

Print

Name:_____ **Date:** _____

Welcome to Omni Family Health!

Print

Our healthcare providers are asking every patient the age of 12 and over to answer a few questions about his/her health habits. These questions are asked in order to provide you with the best and most complete care possible by allowing your doctor to get a better understanding of your health habits. This form is confidential and will not be released to anyone outside of Omni Family Health without your signed permission. If you have any questions, please feel free to ask the front office staff for clarification.

Patient Health Questionnaire- 2 (PHQ-2)

Over the last two weeks, how often have you been bothered by any of the following problems?	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 ☐

For office coding: __**0**__ **+** _____ **+**_____ **+** _____

= Total Score 0_____

If the total score is more than zero (0), please proceed to answer the next questionnaire PHQ-9.

Patient Health Questionnaire- 9 (PHQ-9)
To be completed every 6 months

Over the last two weeks, how often have you been bothered by any of the following problems?	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 asleep, 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, feeling that you are a failure, or feeling that you have let yourself or family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentration 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 being so fidgety or restless that you have been moving around a lot more than usual	0 ☐	1 ☐	2 ☐	3 ☐
9. Thinking that you would be better off dead, or that you want to hurt yourself in someway	0 ☐	1 ☐	2 ☐	3 ☐
Add Columns				
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 ☐

Staying Healthy Assessment

12 – 17 Years

Print

Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	Grade in School:
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			School Attendance Regular? ☐ Yes ☐ 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 drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes ○	No ○	Skip ○	Nutrition
2	Do you eat fruits and vegetables at least 2 times per day?	Yes ○	No ○	Skip ○	
3	Do you eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No ○	Yes ○	Skip ○	
4	Do you drink more than 12 oz. (1 soda can) per day of juice drink, sports drink, energy drink, or sweetened coffee drink?	No ○	Yes ○	Skip ○	
5	Do you exercise or play sports most days of the week?	Yes ○	No ○	Skip ○	Physical Activity
6	Are you concerned about your weight?	No ○	Yes ○	Skip ○	
7	Do you watch TV or play video games less than 2 hours per day?	Yes ○	No ○	Skip ○	
8	Does your home have a working smoke detector?	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 ○	
10	Do you always wear a seatbelt when riding in a car?	Yes ○	No ○	Skip ○	
11	Do you spend time in a home where a gun is kept?	No ○	Yes ○	Skip ○	
12	Do you spend time with anyone who carries a gun, knife, or other weapon?	No ○	Yes ○	Skip ○	
13	Do you always wear a helmet when riding a bike, skateboard, or scooter?	Yes ○	No ○	Skip ○	
14	Have you ever witnessed abuse or violence?	No ○	Yes ○	Skip ○	
15	Have you been hit, slapped, kicked, or physically hurt by someone (or have you hurt someone) in the past year?	No ○	Yes ○	Skip ○	
16	Have you ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No ○	Yes ○	Skip ○	
17	Do you brush and floss your teeth daily?	Yes ○	No ○	Skip ○	Dental Health
18	Do you often feel sad, down, or hopeless?	No ○	Yes ○	Skip ○	Mental Health
19	Do you spend time with anyone who smokes?	No ○	Yes ○	Skip ○	Alcohol, Tobacco, Drug Use
20	Do you smoke cigarettes or chew tobacco?	No ○	Yes ○	Skip ○	
21	Do you use or sniff any substance to get high, such as marijuana, cocaine, crack, Methamphetamine (meth), ecstasy, etc.?	No ○	Yes ○	Skip ○	

22	Do you use medicines not prescribed for you?	No	Yes	Skip	
23	Do you drink alcohol once a week or more?	No	Yes	Skip	
24	If you drink alcohol, do you drink enough to get drunk or pass out?	No	Yes	Skip	
25	Do you have friends or family members who have a problem with drugs or alcohol?	No	Yes	Skip	
26	Do you drive a car after drinking, or ride in a car driven by someone who has been drinking or using drugs?	No	Yes	Skip	
	Your answers about sex and family planning cannot be shared with anyone, including your parents, without your permission.				
27	Have you ever been forced or pressured to have sex?	No	Yes	Skip	Sexual Issues
28	Have you ever had sex (oral, vaginal, or anal)? *If no, skip to question 35.*	No	Yes	Skip	
29	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
30	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
31	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
32	The last time you had sex, did you use birth control?	Yes	No	Skip	
33	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
34	Did you or your partner use a condom the last time you had sex?	Yes	No	Skip	
35	Do you have any questions about your sexual orientation (who you are attracted to) or gender identity (how you feel as a boy, girl, or other gender)?	No	Yes	Skip	
36	Do you have any other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Print

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date: