

PATIENT REGISTRATION FORM

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First Name:		Middle Name:		Last Name:		Date of birth:	
Social Security #		Birth Sex: Female Male Undifferentiated Unknown		Gender Identity: Choose not to disclose Female Female-to- Male(FTM)/Transgender Male Male Male-to-Female (MTF)/ Transgender Female Neither exclusively male nor female		Sexual Orientation: Bi-sexual Chose not to disclose Don't know Lesbian, gay, or homosexual Straight or heterosexual Something else/please describe	
Marital Status: Divorced Married Life Partner Legally Separated Domestic Partner Widow Single		Current Gender: Female Male Undifferentiated				Preferred Pronoun: Asked but unknown Decline to answer He/Him/His She/Her/Hers They/Them/Theirs Ze/Hir Other	
Race: African-American / Black Native American or Alaska Native Native Hawaiian/Pacific Islander		Caucasian / White Asian Other (specify)		Ethnicity: Latino/Hispanic Non-Latino/Hispanic		Homeless: Lives in a shelter In Transition Lives in the Streets Doubling up Not Homeless	
				Are you a Veteran of the US military: Yes No			
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		Which language are you most comfortable using? English Spanish Other (Specify)					
e-mail address:							
How did you hear about us? Friend/ Family member Other (Specify)		Television Radio Referral Billboard 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)							Office use: Yes- #1, #4, #5 "Seasonal" Yes- #2, #3 "Migrant"
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 farm 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							
5. Have you or a family member stopped working in agriculture (farm work) because a disability or age? Yes No							
How many people are in your family? Family size: _____		Whom may we contact in case of emergency? Name: _____ Relationship: _____ Telephone: _____					
Yearly Income: _____							
What type of Health Insurance do you have? Private Insurance Medi-Cal Medicare No Insurance		Responsible Person (Parent or Legal Guardian signing this form) First Name: _____ Last Name: _____ Mailing Address: _____ City _____ State _____ Zip Code _____ Contact Number: _____ Relationship to Patient: _____				DOB: _____	
Authorization and Consent :		<ul style="list-style-type: none"> I/ patient 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, deductibles, and co-payments. I/patient representative authorize the release of medical information to other entities in order to resolve the claim. (Refer to Notice of Privacy Policies) I/patient decline consent the right in submitting an application for the sliding scale fee discount 					
		Signature of Patient/Guardian _____ Date: _____					

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

- | | |
|---|--|
| <ul style="list-style-type: none">▪ I understand I have the right to review this office's <u>Notice of Privacy Policies</u> as displayed in the waiting room.▪ I have received a copy, and read the <u>Notice of Privacy Policies</u> 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. | <ul style="list-style-type: none">▪ 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

1 – 2 Years

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:
Nutrition

1	Do you breastfeed your child?	Yes	No	Skip
2	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip
3	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip
4	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip
5	Does your child drink more than one small cup (4 – 6 oz.) of juice per day?	No	Yes	Skip
6	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip
7	Does your child play actively most days of the week?	Yes	No	Skip
8	Are you concerned about your child's weight?	No	Yes	Skip
9	Does your child watch TV or play video games?	No	Yes	Skip
10	Does your home have a working smoke detector?	Yes	No	Skip
11	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip
12	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip
13	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip
14	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip

Physical Activity

Safety

15	Do you always stay with your child when she/he is in the bathtub?	Yes	No	Skip	
16	Do you always place your child in a rear facing car seat in the back seat?	Yes	No	Skip	
17	Is the car seat you use the right one for the age and size of your child?	Yes	No	Skip	
18	Do you always check for children before backing your car out?	Yes	No	Skip	
19	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
20	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
21	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	Dental Health
22	Do you help your child brush and floss her/his teeth daily?	Yes	No	Skip	
23	Does your child spend time with anyone who smokes?	No	Yes	Skip	
24	Do you have any other questions or concerns about your child'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:
SHA ANNUAL REVIEW					
PCP's Signature		Print Name:			Date: