PATIENT REGISTRATION FORM



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First Name:	Middle Name	:	Last Name:		Date of birt	:h:	
Social Security # Marital Status: Divorced Married Life Partner Legally Separated Domestic Partner Widow Single	Birth Sex: Female Male Undifferentiated Unknown Current Gender: Female Male Undifferentiated	Gender Identity: Choose not to di Female Female-to- Male(FTM)/Tran Male Male-to-Female Transgender Fen Neither exclusive	sgender Male (MTF)/ nale	Sexual Orientation: Bi-sexual Chose not to disclose Don't know Lesbian, gay, or homosexual Straight or heterosexual Something else/please describe		Preferred Pronoun: Asked but unknown Decline to answer He/Him/His She/Her/Hers They/Them/Theirs Ze/Hir Other	
Race: African-American / E Native American or Alask Native Hawaiian/Pacific I Mailing Address: (include suite	a Native Asian slander Other (specify)	Ethnicity: Latino/Hispanic Non-Latino/Hispan City	Homeless:	Lives in a shelter In Transition Lives in the Streets Doubling up Not Homeless State	military:	a Veteran of Yes No	the US
Physical Address: (if different)		City		State	·	Code	
In the past two years, have you work? Yes No Have you or a member of your Are you seeking employment i	receiving: te P Y N Friend/ Family member ork: (planting, picking, preparing to ror anyone in your family, worke to or a member of your family mover family stopped migrating to work an agriculture? Yes No er stopped working in agriculture mily? Whom may we con	Which language are y English Spani Television Radio the soil, packing house, dairy, d in any type of agriculture fa yed to another area and lived k in agriculture (farm work) b	text message ou most comfor ish Other (S Referral Bil driving a truck for irm work? Yes away from home i ecause of a disabilit ability or age?	rtable using? pecify) Ilboard Social Med any type of farm work) No in order to work in any type ity or age? Yes No	rresponde lia Bus e of agricult	Mailer	On-line Ad Office use: Yes-#1, #4, #5 "Seasonal" Yes-#2, #3 "Migrant"
		· Legal Guardian signing th		DO			
Medicare	Mailing Address:				State	Zip	Code
Authorization and Consent :	dental condition. I understo may pay less than the actu	onsent I am presenting at Omn and I am financially responsible al bill; this includes the remain thorize the release of medical ent the right in submitting	e for all charges ren ng balance after p information to othe g an application for	examination, diagnosis, and dered for services to my de agyment of insurance benef er entities in order to resolve or the sliding scale fee discou	pendents or fits, deductik the claim. (unt	r me as my insurd oles, and co-pay Refer to Notice	ance carrier ments.

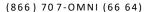
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT CONSENT FOR USE AND DISCLOSURE FOR TREATMENT, PAYMENT &

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 operations this includes assignment of benefits. I consent to examinations, treatments, procedures and blood tests of tests for communicable diseases such as hepatitis and HIV/AIDS.	ole health information to carry out treatment, payment or health care rdered by my physician and health care providers, including blood
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)):	
	Date
Printed name of patient or patients' representative:	Relationship:
Section B: Authorization to Share Protected Health Infor In order to disclose or discuss any personal health information to you	r family or designee, we must have a signed consent on file allowing se with your family member or designee. Please list the names of those in be changed or revoked at any time with your permission.
Name:	
	Relationship:
	Relationship:
I authorize Omni Family Health to share information related to my he	
I understand this might include information such as: diagnosis, progn reminders, medical billing, insurance and any other medical informa	osis, and treatment plans, medications, test results, appointment
lacksquare I decline to have my medical information shared with fami	y or designee.
Patient signature:	Date:

ADVANCE DIRECTIVES ACKNOWLEDGMENT



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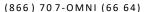
Representative signature

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

PATIENT RIGHTS AND RESPONSIBILITIES



• www.OmniFamilyHealth.org



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

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PATIENT INFORMATION SECTION 1

Name: (First)	(Middle)		(Last)	Date:				
, ,								
Social Security Nur	nber:		Date of Birth:					
Marital Status:	Single	Married	Divorced	Widow				
Spouses Name:								
oatient Name:			Applicant Relationshi	p to Patient:				
			OLD INFORMATION SECTION II					
who reside in the had not be needed in the had not be needed to the needed to the needed to the needed in the need	nousehold and contrib gross (pre-tax) wages, cial security benefits, t income, etc. DO NC ent subsidies. In order	oute to the k child suppo public/gove oT include no to be consid	ourself). Include anyone at leas basic living expenses of the hou ort income, alimony income, ren ernment assistance, pensions and on-cash assistance such as food dered a household member, the with zero income must provide	sehold (including yourself). Ital income, unemployment Ind/or IRA distribution income It stamps, housing allowance, It person must be listed				
	lame and Last)	Age	Source of Income or Employer Name	Monthly Income				
Please include inc	ome documentation	for each AD	DULT listed above.					
Total # of adults (1	8 years of age and o	lder):						
Total # of children	(under the age of 18):						
Total # of househo	old 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

3 - 4 Years

Child's Name (first & last)		Date of Birth	te of Birth Female Today's Date Male		e In	In Child/Day Care?			
Person Completing Form Parent Relative Fr					Guardia	n Ne	Need Help with Form?		
Other (Specify)									
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									
any	thing on this form. Your answers will b	e protected as pa	irt of your med				Clinic Use Only:		
1	Does your child drink or eat 3 serving daily, such as milk, cheese, yogurt,	-		Yes	No	Skip	Nutrition		
2	Does your child eat fruits and veget per day?	ables at least tw	o times	Yes	No	Skip			
3	Does your child eat high fat foods, sice cream, or pizza more than once		ds, chips,	No	Yes	Skip			
4	Does your child drink more than on of juice per day?	6 oz. cup)	No	Yes	Skip				
5	Does your child drink soda, juice dr drinks, or other sweetened drinks m		No	Yes	Skip				
6	6 Does your child play actively most days of the week?				No	Skip	Physical Activity		
7	7 Are you concerned about your child's weight?				Yes	Skip			
8	Does your child watch TV or play v hours per day?	Yes	No	Skip					
9	Does your home have a working smoke detector?				No	Skip	Safety		
10	Have you turned your water temperature down to low-warm (less than 120 degrees)?				No	Skip			
11	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?				No	Skip			
12	Does your home have cleaning supplies, medicines, and matches locked away?				No	Skip			
13	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?				No	Skip			
14	Do you always stay with your child bathtub?	Yes	No	Skip					

15	Do you always place your child in a forward facing car seat in the back seat?	Yes	No	Skip	
16	Is the car seat you use the right one for the age and size of your child?	Yes	No	Skip	
17	Do you always check for children before backing your car out?	Yes	No	Skip	
18	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
19	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
20	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
21	Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	Skip	
22	Do you help your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
23	Does your child spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
24	Do you have any other questions or concerns about your child's development, health or behavior?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
Nutrition					
☐ Physical Activity					
Safety					
☐ Dental Health					
☐ Tobacco Exposure					☐ Patient Declined the SHA
PCP's Signature		Pr	int Name:		Date:
			SHA ANNUAL	REVIEW	
PCP's Signature		Pr	rint Name:		Date:
PCP's Signature		Pr	int Name:		Date:
Tot Soignature		1 1	me manic.		Dutc.