PATIENT REGISTRATION FORM

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Omni Family Health

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

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 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

Preferred Pronoun:
- ○ Asked but unknown
- ○ Decline to answer
- ○ He/Him/His
- ○ She/Her/Hers
- ○ They/Them/Theirs
- ○ Ze/Hir
- ○ Other

Race: ○ African-American / Black ○ Caucasian / White ◉ Native American or Alaska Native ○ Asian ○ Native Hawaiian/Pacific Islander ○ 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
e-mail address:

Which language are you most comfortable using? ○ English ○ Spanish ○ Other (Specify)

How did you hear about us? ◉ Friend/ Family member ○ Television ○ Radio ○ Referral ○ Billboard ○ Social Media ○ Bus ○ Mailer ○ On-line Ad ○ Other (Specify)

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 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

Office use:
Yes- #1, #4, #5 "Seasonal"
Yes- #2, #3 "Migrant"

How many people are in your family?
Family size: _____

Yearly Income: _____

Whom may we contact in case of emergency?

Name: _____ Relationship: _____

Telephone:

What type of Health Insurance do you have?
- ○ Private Insurance
- ◉ Medi-Cal
- ○ Medicare
- ○ No Insurance

Responsible Person (Parent or Legal Guardian signing this form) DOB:
First Name: Last Name

Mailing Address: City State Zip Code

Contact Number: Relationship to Patient:

Authorization and Consent :

- 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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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

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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

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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

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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: _____

Name: _____ **Date:** _____

Welcome to Omni Family Health!

Our healthcare providers are asking every patient over the age of 18 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.

DAST-10
To be completed once a year

The DAST-10 was designed to provide a brief instrument for clinical screening and treatment evaluation and can be used with adults and older youth. The following questions concern information about your potential involvement with drugs **excluding** alcohol and tobacco during the past 12 months.

When the word "drug abuse" is used, they mean the use of prescribed or over-the-counter medications used in excess of the directions and any non-medical use of any drugs.

The various classes of drugs may include but are not limited to: cannabis (marijuana, hash), solvents (gas, paints, etc.), tranquilizers (valium), barbiturates, cocaine, stimulants (speed), hallucinogens (LSD), or narcotics (heroin).

These questions refer to the past 12 months only.	Yes	No
1. Have you used drugs other than those required for medical use?		
2. Do you abuse more than one drug at a time?		
3. Are you always able to stop using drugs when you want to?		
4. Have you had “blackouts” or “flashbacks” as a result of drug use?		
5. Do you ever feel bad or guilty about your drug use?		
6. Does your spouse (or parent) ever complain about your involvement with drugs?		
7. Have you neglected your family because of your use of drugs?		
8. Have you engaged in illegal activities in order to obtain drugs?		
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?		
10. Have you had medical problems as a result of your drug use (memory loss, hepatitis, convulsions, bleeding)?		
***DAST Score**		

Print

Name: _____ **Date: _____**

CAGE Questioner
To be completed once a year

	Yes	No
Have you ever felt you should **C**ut down on your drinking?	☐	☐
Have people **A**nnoyed you by criticizing your drinking?	☐	☐
Have you ever felt **G**uilty about your drinking?	☐	☐
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye opener)?	☐	☐

Print

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

Senior

Print

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ Other *(Specify)*		Need help with form? ☐ 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 every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Do you have difficulty chewing or swallowing?	No	Yes	Skip	
8	Are you concerned about your weight?	No	Yes	Skip	
9	Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least ½ hour a day?	Yes	No	Skip	Physical Activity
10	Do you feel safe where you live?	Yes	No	Skip	Safety
11	Do you often have trouble keeping track of your medicines?	No	Yes	Skip	
12	Are family members or friends worried about your driving?	No	Yes	Skip	
13	Have you had any car accidents lately?	No	Yes	Skip	
14	Do you sometimes fall and hurt yourself, or is it hard to get up?	No	Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone in the past year?	No	Yes	Skip	
16	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
17	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
18	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
19	Do you often have trouble sleeping?	No	Yes	Skip	
20	Do you or others think that you are having trouble remembering things?	No	Yes	Skip	

21	Do you smoke or chew tobacco?	No ○	Yes ○	Skip ○	Alcohol, Tobacco, Drug Use
22	Do friends or family members smoke in your house or where you live?	No ○	Yes ○	Skip ○	
23	In the past year, have you had 4 or more alcohol drinks in one day?	No ○	Yes ○	Skip ○	
24	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No ○	Yes ○	Skip ○	
25	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No ○	Yes ○	Skip ○	Sexual Issues
26	Have you or your partner(s) had sex with other people in the past year?	No ○	Yes ○	Skip ○	
27	Have you or your partner(s) had sex without a condom in the past year?	No ○	Yes ○	Skip ○	
28	Have you ever been forced or pressured to have sex?	No ○	Yes ○	Skip ○	
29	Do you have someone to help you make decisions about your health and medical care?	Yes ○	No ○	Skip ○	Independent Living
30	Do you need help bathing, eating, walking, dressing, or using the bathroom?	No ○	Yes ○	Skip ○	
31	Do you have someone to call when you need help in an emergency?	Yes ○	No ○	Skip ○	
32	Do you have 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
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐
☐ Independent Living	☐	☐	☐	☐

Comments:

☐ **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: