Instructions: This form may be completed online, however, you must print out to sign it. You may print, complete, sign and scan back to PatientServices@outpatientmedical.org, or you may print and physically return to the clinic front desk. (This document MUST have a wet signature on Page 3 and a wet initial on Pages 3 and 4.)

Patient Information

First Name:	**Last Name:**		**Middle Initial:**
Physical Address:	**City:**	**State:**	**Zip code:**
Mailing Address (☐ Same as Physical):	**City:**	**State:**	**Zip code:**
Primary Phone#:	**Secondary Phone#:**		
Date of Birth: / **Sex at Birth: ☐ Male ☐ Female**	**Age:**	**SSN:**	
Email Address:			
Preferred Pharmacy:	**Pharmacy Phone #:**		
Primary Care Provider:	**Phone #:**		
Other Healthcare Provider:	**Phone #:**	**Specialty:**	
Other Healthcare Provider:	**Phone #:**	**Specialty:**	
Other Healthcare Provider:	**Phone #:**	**Specialty:**	

Emergency Contact

Name:	**Phone#:**	**Relationship to Patient:**
Name:	**Phone# :**	**Relationship to Patient:**

Insurance Information

Do You Or Anyone In Your Household Have Healthcare Coverage? ☐ Yes (☐ Medical / ☐ Dental) ☐ No (Self Pay)			
Please Check All That Apply To Your Household: ☐ Private Insurance ☐ Medicare ☐ Medicaid			
Primary Insurance:	**Policy #:**		**Group #:**
Name of Card Holder:	**SSN:**		**DOB:**
Cardholder Employer:	**Occupation:**		

Secondary Insurance:	Policy #:	Group #:
Name of Cardholder:	SSN:	DOB:
Card Holder Employer:	Occupation:	

Guarantor Information
(Person Financially Responsible)

Check Here If Same As Patient ☐

Guarantor Name:	Guarantor Phone #:
Guarantor SSN:	Guarantor DOB:

Patient Demographics
(Please Complete for Federal Grant Support)

Patients by Gender Identity:
- ☐ Male
- ☐ Female
- ☐ Transgender man / transgender male / trans masculine
- ☐ Transgender woman / transgender female / trans feminine
- ☐ Other
- ☐ Unknown
- ☐ Choose Not to Disclose

Sexual Orientation:
- ☐ Straight or Heterosexual
- ☐ Lesbian or Gay
- ☐ Bisexual
- ☐ Other
- ☐ Unknown
- ☐ Do not know
- ☐ Choose Not to Disclose

Ethnicity:
☐ NON Hispanic or Latino ☐ Hispanic or Latino ☐ Choose Not to Disclose Ethnicity

Race (Check All That Apply):
- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ American Indian / Alaskan Native
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ More than one race
- ☐ Unreported / Choose not to disclose

Disclosure of Income:

Gross Annual Income: $_____

☐ Choose Not to Disclose

Primary Language Spoken: _____ Interpreter Needed?: ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Life Partner

Are You Homeless? ☐ Yes ☐ No Are You A Veteran? ☐ Yes ☐ No	Agriculture Status: ☐ Not Agricultural Worker ☐ Migrant Worker ☐ Seasonal Worker ☐ Dependent of a Migrant Worker ☐ Dependent of a Seasonal Worker

Required Authorizations

Consent to Treatment:

I consent to any assessments, examinations, diagnostic tests, treatments, and procedures performed by OMC Providers either face to face and/or telehealth. I further understand that I may revoke this authorization, in writing, at any time. _____
Initial

Financial Responsibility:

I understand that I am responsible for the cost of all services rendered, unless I have healthcare coverage for services provided to me. I understand that I am responsible for either a clinic fee/deposit (uninsured) or copay (required by my private insurance plan) at the time of service. I understand that if I have healthcare coverage that my plan will be billed: however, I agree to pay all charges for any health care services provided by Outpatient Medical Center, Inc., that are not covered or collected from my insurance carrier or other third party payer, including any deductibles and coinsurance amounts. _____
Initial

This form was completed by: ☐ Patient ☐ Parent ☐ Guardian ☐ Other: _____

The information above is accurate to the best of my knowledge.

_____ _____ _____
Signature of Patient or Representative (Must be a wet Signature) | Printed Name | Date

Please list all family members who will have authority to discuss your protected health information:

☐ I DO NOT authorize OMC to discuss my protected health information with anyone besides myself.

☐ I DO authorize OMC to discuss my protected health information (Please Check One):
☐ All ☐ Medical Only ☐ Dental Only ☐ Behavioral Health / Psychiatry Only

Authorized Person:	Relationship:
Home Phone#:	Cell Phone#:

☐ I DO authorize OMC to discuss my protected health information (Please Check One):
☐ All ☐ Medical Only ☐ Dental Only ☐ Behavioral Health / Psychiatry Only

Authorized Person:	Relationship:
Home Phone#:	Cell Phone#:

Patient Information Documents:

- Statement of P*atient Rights and Responsibilities* – defines my rights and responsibilities as a patient that received health care services from Outpatient Medical Center, Inc., and includes the Patient Complaint Procedure / Notice Concerning Complaints – explains how to file a complaint and/or grievance.

- ***Notice of Privacy Practices*** **– provides information about how Outpatient Medical Center, Inc. and its workforce may use and/or disclose my protected health information for treatment, payment, health care operations and as otherwise permitted by law.**

Acknowledgement of Receipt:

I acknowledge and agree that I have received a copy of my *Patient Rights and Responsibilities*. I understand that if I neglect to fulfill my responsibilities that I may be terminated as a patient of the clinic. _____
Initial

I acknowledge and agree that I have received a copy of *OMC's Notice of Privacy Practices*. By signing this form, I consent OMC's use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. _____
Initial

How Did You Hear About Us? (Please Check One):

☐ Employee ☐ Patient/Friend ☐ Flyer/Brochure ☐ OMC Website ☐ Newspaper ☐ Facebook/Social Media ☐ Other _____

FOR OFFICE USE ONLY:

ITEMS NEEDED FOR REGESTERING AS A OMC PATIENT: (PLEASE CHECK ALL PROVIDED BY PATIENT AND SCANNED INTO THE SYSTEM)

A. *Picture Identification:*

- **☐ Driver's License or State Issued ID**
- **☐ Passport**
- **☐ U.S. Military ID**
- **☐ U.S. Permanent Resident Card**
- **☐ Consular or International ID Card**
- **☐ Foreign Government Issued ID**
- **☐ Birth Certificate (Children)**
- **☐ High School or College Student ID**
- **☐ School Records (Children)**
- **☐ Employer Issued Identification Card**
- **☐ Transportation Worker ID Credential Card (TWIC)**
- **☐ US Immigration Documents**

B. *Proof of Address:*

- **☐ Current Driver's License**
- **☐ Current State Issued ID**
- **☐ Consular or International ID Card**
- **☐ School Registration Records (Children)**
- **☐ Voter's Registration**
- **☐ Automobile Insurance Documents**
- **☐ Business Mail Postmarked within 30 days**
- **☐ Utility Bill (Electric, Water, Gas, Phone/Cell, Cable TV)**
- **☐ Current Lease Agreement (Signed)**
- **☐ Federal/State Housing Documents**
- **☐ Mortgage Documents (Signed)**
- **☐ Property Tax Documents (Within 12 Months)**

Documents verified and scanned into the system by (PSR): _____ Date: _____