



Outpatient Medical Center, Inc.

New Patient Registration Form

(For all patients new to OMC or not seen in any OMC Clinic in the last 2 years)

OMC Natchitoches OMC SBHC OMC Leesville OMC Tallulah

Patient Information

First Name:		Last Name:		Middle Initial:
Physical Address:		City:	State:	Zip code:
Mailing Address (<input type="checkbox"/> Same as Physical):		City:	State:	Zip code:
Primary Phone#:		Secondary Phone#:		
Date of Birth:	Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes (<input type="checkbox"/> Medical / <input type="checkbox"/> Dental) <input type="checkbox"/> No (Self Pay)		
Please Check All That Apply To Your Household: <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> 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)

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

<p>Race (Check All That Apply):</p> <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> More than one race <input type="checkbox"/> Unreported / Choose not to disclose	<p>Disclosure of Income: <i>Used for statistical purposes only Does NOT affect your access to care</i></p> <p>Gross Annual Income: \$ _____</p> <p>Household Size (#): _____</p> <input type="checkbox"/> Choose Not to Disclose
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Primary Language Spoken: _____ **Interpreter Needed?:** Yes No

Marital Status: Single Married Divorced Widowed Separated Life Partner

<p>Are You Homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are You A Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Agriculture Status:</p> <input type="checkbox"/> Not Agricultural Worker <input type="checkbox"/> Migrant Worker <input type="checkbox"/> Dependent of a Migrant <input type="checkbox"/> Seasonal Worker <input type="checkbox"/> Dependent of a Seasonal Worker
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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

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 *Patient 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 REGISTERING AS A OMC PATIENT: (PLEASE CHECK ALL PROVIDED BY PATIENT AND SCANNED INTO THE SYSTEM)

A. *Picture Identification:*

- | | |
|--|--|
| <input type="checkbox"/> Driver's License or State Issued ID | <input type="checkbox"/> Birth Certificate (Children) |
| <input type="checkbox"/> Passport | <input type="checkbox"/> High School or College Student ID |
| <input type="checkbox"/> U.S. Military ID | <input type="checkbox"/> School Records (Children) |
| <input type="checkbox"/> U.S. Permanent Resident Card | <input type="checkbox"/> Employer Issued Identification Card |
| <input type="checkbox"/> Consular or International ID Card | <input type="checkbox"/> Transportation Worker ID Credential Card (TWIC) |
| <input type="checkbox"/> Foreign Government Issued ID | <input type="checkbox"/> US Immigration Documents |

B. *Proof of Address:*

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

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