OMNI MEDICAL CENTER
PATIENT INFORMATION FORM
(Please print and complete all sections below)

Is your condition a result of work injury? Yes __ No __ (if YES, please ask for other form)

Patient Information:

Name ____________________________________ __________________________________ _________
Last Name First Name MI

Marital Status: Single /Married / Other Sex: M / F Driver License # _________________

SSN __________-_________-_________ Date of Birth (MM/DD/YYYY) _____/____/______

Address ____

City ___________________________________ State _____________________ Zip ________________

Home Phone ( )______-__________ Work ( ) _____- _________ Cell ( ) _____-__________

Email Address ____

Employer Name ______________________________ Occupation ______________________________

Work Address: ____City ___________ Zip ____________

Advance Directive Yes____ No _____ N/A (if patient is under age of 18) _____

Description ____

How did you hear about us? By physician ____

By current patient ____

By Newspaper /Yellow pages / Internet / Referral Services

Primary Insured Information

Relationship with Primary Insured: Self / Spouse / Child / Other

If you **did not** check SELF, please fill out the following information about the responsible person:

Name ____________________________________ __________________________________ _________
Last Name First Name MI

Marital Status: Single /Married / Other Sex: M / F Driver License # _________________

SSN __________-_________-_________ Date of Birth (MM/DD/YYYY) _____/____/______

Address ____(APT# _________)

City ___________________________________ State _____________________ Zip ________________

Home Phone ( )______-__________ Work ( ) _____- _________ Cell ( ) _____-__________

Guarantor Information (Who brings the minors in)

Relationship with Primary Insured: Self / Spouse / Child / Other

If you **did not** check SELF, please fill out the following information about the responsible person:

Name ________________________________ ______________________________ ________
Last Name First Name MI

Marital Status: Single /Married / Other Sex: M / F Driver License # ________________

SSN _________-________-________ Date of Birth (MM/DD/YYYY) _____/____/______

Address ____(APT# ________)

City ________________________________ State ____________________ Zip _______________

Home Phone ( )______-_________ Work ( ) _____- ________ Cell ( ) _____-_________

Emergency Contact

Name of person: ____________________________ Relationship __________

Address ____(APT# ________)

City ____ State ___________ Zip _______________

Home Phone ( )______-_________ Work ( ) _____- ________ Cell ( ) _____-_________

Pharmacy Information

Name of Pharmacy: ____

Pharmacy Phone #: ____

Address of Pharmacy: ____

City, State, Zip code: ____

Omni Medical Center

Patient Consent Form

In April of 2003, new federal requirements regarding privacy of information for health care patients take effect. H.I.P.A.A., the Health Insurance Portability and Accountability Act require that all medical providers, insurance companies and others put in place controls to ensure that your personal medical information is safe. OMNI Medical Center requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Signature of Patient or Representative:____ Date:_____________

Printed Name of Patient/Representative: ____Date of Birth: _________

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request the results of test and procedures. Under the requirements for the H.I.P.A.A., we are not allowed to give this information to anyone without the patient's consent. If you wish to have your test results released to family members you must sign this form. Signing this form will only give consent to release laboratory and radiology results to the family members indicated below. This consent form will not allow OMNI Medical Center Associates to release any other information to these family members.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize OMNI Medical Center Associates to release my laboratory/radiology results and all medical related reports to the follow individuals,

I. Name: ____Relation to Patient: ________

2. Name: ____Relation to Patient: ________

Patient Printed Name: ____

Patient/Representative Signature:____

Authorization to Leave Messages with Household Members/Answering Machine

From time to time it is necessary for representatives of OMNI Medical Center to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss lab or procedure results, or to ask a patient to call OMC regarding an issue or concern. At no time will a representative of OMC discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine. Your have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient/Representative Signature ____ Date: ______________

Consent to Photo

I hereby authorize Omni Medical Center to take digital photographs of me. I understand that the photograph is only be used for my personal medical record serving a purpose of identification.

Patient/Representative Signature: ____ Date: _______________

Assignment of Benefits / Financial Agreement

I hereby authorize my insurance benefits to be paid directly to the physician and I am responsible for non-covered services. I am also financially responsible for all fees for services rendered, monthly billing charges and collection charges. The undersigned, as the patient or on behalf of the patient, hereby consents to and authorizes all diagnostic and therapeutic treatments considered necessary and advisable by the medical staffs of the practice to include:

Physical exam, medical and surgical treatments and procedures, emergency treatments and procedures or services, laboratory procedures, injections, vaccinations and X-rays. I have read the above consent for release of information. I do hereby acknowledge that I am familiar and fully understand the terms and conditions of the consent. In addition, I received the Terms and Conditions information packet.

Patient/Representative Signature ____Date:___________________

Omni Medical Center

4040 McDermott Rd, Ste 100
Plano, TX 75025
Phone: 972-668-6868, 972-884-4160

3413 Spectrum Blvd, Ste 100
Richardson, TX 75082
fax: 972-668-1618

Insurance Verification Disclosure/Agreement

As a courtesy, **Omni Medical Center** will verify and file my health insurance. However, verification of my insurance benefits does **NOT** guarantee payment for services rendered. As such, in the event of my health insurance non-payment or limitations, I am financially responsible for all charges incurred.

Patient Name (Printed) ______________________________

Date ________________

Patient Signature

____

Parent/Guardian Signature

____

Office Manager/Staff ____________________________________

Date ________________