www.heartofohiofamilyhealth.org

Capital Park Family Health Center
2365 Innis Road
Columbus, Ohio 43224
614-416-4325

Whitehall Family Health Center
882 South Hamilton Road
Columbus, Ohio 43213
614-235-5555

HEART OF OHIO FAMILY HEALTH

PATIENT REGISTRATION FORM

PERSONAL INFORMATION

Last Name: _____ **First Name:** _____ **M.I.** ____ **Preferred Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Best Phone: _____ **Work Phone:** _____ **Cell/Alt Phone:** _____

Date of Birth: _____ **Social Security #:** _____ **Student Status:** ☐ Full time ☐ Part time ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated **How did you hear about us?** _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Disabled ☐ Retired **Email** _____

Emergency Contact Name: _____ **Phone:** _____ **Relationship to Patient:** _____

RESPONSIBLE PARTY/GUARANTOR IF DIFFERENT FROM THE PATIENT

Responsible Party Last Name: _____ **First Name:** _____ **M.I.** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell/Alt Phone:** _____

Gender: ☐ **Male** ☐ **Female** **Date of Birth:** _____ **Social Security #:** _____

Employer: _____ **Email:** _____

MEDICAL INSURANCE INFORMATION (Must Present Insurance Card)

Primary Insurance Company: _____ **ID Number:** _____

Name of Insured: _____ **Insured Date of Birth:** _____ **Relationship to Patient:** _____

Secondary Insurance Company: _____ **ID Number:** _____

Name of Insured: _____ **Insured Date of Birth:** _____ **Relationship to Patient:** _____

ADDITIONAL INFORMATION

Country of Origin: _____ **Language:** _____ **Do you need an Interpreter?** ☐ Yes ☐ No

Race: ☐ Black/ African-American ☐ White ☐ American Indian/Native Alaskan ☐ Asian
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Multiple Races ☐ Decline to respond

Check yes or no for each	yes	no	Check yes or no for each	yes	no
Hispanic/Latino			Homeless*		
Migrant Worker			Veteran		
Seasonal Worker			Legal Resident/Citizen of the US*		

*used only to determine eligibility of certain health care programs and is not reported to any government or law enforcement agency

Do you think of yourself as: ☐ Male ☐ Female ☐ Female-to-Male (FTM) ☐ Male-to-Female (MTF) ☐ Genderqueer (neither exclusively)
☐ Additional/Other ☐ Decline to Answer

Do you think of yourself as: ☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual ☐ Something Else ☐ Don't Know

Sex Assigned on Birth Certificate: ☐ Male ☐ Female

Household Annual Income: ☐ $0-20,000 ☐ $20,000-50,000 ☐ $50,000-75,000 ☐ $75,000-100,000 ☐ $100,000+

Household Size: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15+

FINANCIAL INFORMATION

"Household Size" is defined as immediate family members who reside at the same address. You MUST include your spouse or domestic partner as part of your household and include their income. Generally, children over the age of 18 and other adults (not spouse or domestic partner) cannot be included as part of your household.

Household Members (including yourself) – use additional space to list more household members if needed				
Name	Social Security Number	Date of Birth / Age	Relation to the applicant	Current patient at HOFHC?
		/	SELF	☐Yes ☐No
		/		☐ Yes ☐ No
		/		☐ Yes ☐ No
		/		☐ Yes ☐ No
		/		☐ Yes ☐ No
		/		☐ Yes ☐ No

FINANCIAL INFORMATION CONTINUED: APPLYING FOR OR REFUSING THE SLIDING FEE PROGRAM

Income information for:

Household Income $_____

Other Income $_____

Total Income $_____

Total dependents in household: _____

Check one box only:

☐ I am refusing the sliding fee discount.

☐ Under penalties of perjury, I certify that I have no income of any kind.

☐ I am applying for Sliding Fee Discount and will provide proof of income.

Proof of income source: Pay stubs, child support, unemployment, disability, social security, self employment earnings, 1040 tax form, etc.

Proof of current income must be provided for the year you wish to receive a sliding fee discount. Proof of identity and residency must also be provided. Birth certificates must be presented for all children under age 18.

For Staff Use Only:

Application Received Date _____ Application Reviewed Date _____ Sliding Fee % _____ Sliding Fee Expiration Date _____ Staff Initials _____

☐ Proof of income received ☐ Proof of dependency received ☐ Incomplete application; patient advised to bring additional documents_____

PATIENT ACKNOWLEDGEMENT

I hereby authorize my insurance carrier to pay benefits directly to Heart of Ohio Family Health Centers (HOFHC). I authorize HOFHC to release any information acquired in the course of my treatment for my medical claims. I understand that I am responsible for all payments and co-insurance amounts, non-covered supplies and services and yearly deductibles. I understand that payment is expected at the time services are rendered. I certify that the above information is correct to the best of my knowledge. I understand that providing false information or false documentation may result in removal from the Financial Assistance Program, possible termination from the practice, and I will forfeit any discounted cost of services.

Payment is expected at the time of service, including all co-pays.

Patient Signature: _____ *Date:* _____

Parent/Guardian Signature: _____ *Date:* _____

Employee Signature: _____ *Date:* _____ *Copied Cards: Y or N*