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

PATIENT REGISTRATION FORM

PERSONAL INFORMATION

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: ____________________ ☐ **Full Time** ☐ **Part Time** ☐ **Unemployed** ☐ **Disabled**

Are you a Student? ☐ **Full time** ☐ **Part time** ☐ **No**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Separated**

Email: ____________________ **Who referred you to our office?** ______________

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: ____________________ **Gender** ☐ **Male** ☐ **Female**

Insured Date of Birth: ______________ **Relationship to Patient:** ☐ **Self** ☐ **Other** ______________

Secondary Insurance Company: ____________________ **ID Number:** ______________

Name of Insured: ____________________ **Gender** ☐ **Male** ☐ **Female**

Insured Date of Birth: ______________ **Relationship to Patient:** ☐ **Self** ☐ **Other** ______________

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**

Ethnicity: **Hispanic/Latino** ☐ **Yes** ☐ **No**

Are you a Migrant Worker? ☐ **Yes** ☐ **No** **Seasonal Worker?** ☐ **Yes** ☐ **No** **Homeless?** ☐ **Yes** ☐ **No** **Veteran?** ☐ **Yes** ☐ **No**

Are you a legal resident/citizen of the United States? ☐ **Yes** ☐ **No**
(used only to determine eligibility of certain health care programs and is not reported to any government or law enforcement agency)

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.

Patient Signature: ______________________________ *Date:* ______________

Parent/Guardian Signature: ______________________________ *Date:* ______________