HEART OF OHIO FAMILY HEALTH
www.heartofohiofamilyhealth

WHITEHALL FAMILY HEALTH
882 S. Hamilton Road
Columbus, OH 43213
(614) 235-5555
F (614) 536-1994

CAPITAL PARK FAMILY HEALTH
2365 Innis Road
Columbus, OH 43224
(614) 235-5555
F (614) 536-1994

CHANTRY FAMILY HEALTH
5560 Chantry Drive
Columbus, OH 43232
(614) 235-5555
F (614) 536-1994

PATIENT REGISTRATION FORM

PERSONAL

Last Name: ________________________ **First Name**:________________________ **M.I.** ____ **Preferred Name**: ____________________

Address: ______________________________________ **City**: ____________________________ **State**: ________ **Zip**:__________

Best Phone:______________________________ **Work Phone**:_______________________ **Cell/Alt Phone**: ______________________

Date of Birth:________________ **Social Security #**:____________________

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

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			Veteran		

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 **Do you live in Public Housing?** ☐Yes ☐No

Household Annual Income: ☐$0-$7,000 ☐$7,001-$14,000 ☐$14,001-$21,000 ☐$21,001-$28,000 ☐$28,001-$35,000
☐$35,001-$42,000 ☐$42,001-$49,000 ☐$49,001-$56,000 ☐$56,001-$63,000 ☐$63,001+

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

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*