Lower Lights
Christian Health Center

(614) 274-1455

Lower Lights Health Center
1160 West Broad Street
Columbus, OH 43222

Lower Lights Nursing Center
777 West State Street, Suite 201
Columbus, OH 43222

Lower Lights East 5th Avenue
171 East 5th Avenue
Columbus, OH 43201

Lower Lights German Village
1560 South High Street
Columbus, OH 43207

Lower Lights Cooper Road
6000 Cooper Road
Westerville, OH 43081

Lower Lights UnionStar
773 Walnut Street
Marysville, OH 43040

Lower Lights Shared Services
1251 West Broad Street
Columbus, OH 43222

Patient Registration Form

PATIENT INFORMATION

Last Name: _____First Name: _____Middle Initial:_____

Address: _____ DOB: _____ SSN: _____

City/State/Zip Code: _____County: _____

Sexual Orientation: Lesbian or Gay, Straight (not Lesbian or Gay), Bisexual, Something Else, Don't know, Choose Not to Disclose

Gender Identity: Male, Female, Transgender Male/Female to Male, Transgender Female/Male to Male, Transgender Female/Male to Female, Other, Choose Not to Disclose

Home Phone Number: _____ Marital Status: Single Married Other

Work Phone Number: _____ Employment Status: Employed PT Student FT Student

Name of Employer: _____ Occupation: _____ Veteran: Y N

Email Address _____

RESPONSIBILITY/ GUARANTOR (IF DIFFERENT FROM PATIENT)

Guarantor Name: _____

Address: _____ DOB: _____ SSN:_____

City: _____ State: _____ Zip Code: _____

Sexual Orientation: Lesbian or Gay, Straight (not Lesbian or Gay), Bisexual, Something Else, Don't know, Choose Not to Disclose

Gender Identity: Male, Female, Transgender Male/Female to Male, Transgender Female/Male to Male, Transgender Female/Male to Female, Other, Choose Not to Disclose

Home Phone Number: _____ Marital Status: Single Married Other

Work Phone Number: _____ Employment Status: Employed PT Student FT Student

Name of Employer: _____

Relationship to Patient: Self Spouse Child Foster-Parent Parent Grandparent Other

EMERGENCY CONTACT/RELATIVE

Last Name: _____First Name: _____ Middle Initial:_____

Patient Name _____

Address: _____ Phone Number: _____

May we leave messages at your home with other residents? Y N

May we leave messages on your voice mail or answering machine? Y N

Patient Signature _____ Date_____

INSURANCE INFORMATION

INSURANCE – MEDICAL

Policy Holder Name: _____

Policy Holder's DOB: _____ SSN: _____

Name of Primary Insurance: _____ Insured ID#: _____ Group# _____

Name of Secondary Insurance: _____ Insured ID#: _____ Group#: _____

Accident: Y N if yes, what type: Auto Home Sports Work Other Date of Accident: _____

INSURANCE – DENTAL

Policy Holder Name: _____

Policy Holder's DOB: _____ SSN: _____

Name of Primary Insurance: _____ Insured ID#: _____ Group# _____

Name of Secondary Insurance: _____ Insured ID#: _____ Group#: _____

Accident: Y N if yes, what type: Auto Home Sports Work Other Date of Accident: _____

INSURANCE – VISION

Policy Holder Name: _____

Policy Holder's DOB: _____ SSN: _____

Name of Primary Insurance: _____ Insured ID#: _____ Group# _____

Name of Secondary Insurance: _____ Insured ID#: _____ Group#: _____

Accident: Y N if yes, what type: Auto Home Sports Work Other Date of Accident: _____

Because Lower Lights Christian Health Center is a Federally Qualified Health Center (FQHC), we are required to track and report demographic data of our patient base. All information is kept strictly confidential, so please complete this page in its entirety. Thank you!

Preferred Language: _____

Patient Name _____

Race: Black/African-American White/Caucasian Native Hawaiian Asian Native-American
Other Pacific Islander American Indian/Alaska Native More than 1 race

Ethnicity (Pick One): Hispanic or Latino All Other

Homeless: Y N
If Homeless where are you staying? Doubling Up Shelter Streets Transitional Unknown

Migrant Worker: Y N Seasonal Worker: Y N

Education (completed) : High School HS/GED Some-College College-Grad Post-Grad

Religious Preference: _____

Are you an Armed Services Veteran? Y N

INCOME INFORMATION (MUST BE COMPLETED BY ALL PATIENTS REGARDLESS OF INCOME OR INSURANCE)

Income Before Taxes: $ _____per Hour Week Bi-week Month Year

Other Income: $ _____

Income Type: Job Retirement Disability Medicaid/ADC SSI None Exp. Date_____

Family Size (# in Household): _____

Ages of Dependents: _____

_____

_____

_____

How did you hear about Lower Lights Christian Health Center? _____

_____

ATTENTION Sliding Fee Scale Patients:
For all uninsured patients, there is minimum $10.00 co-pay for each visit regardless of sliding fee scale status.

Failure to submit all requested documents within 60 days of initial visit will result in a denial of the sliding fee scale discount and you will be responsible for the entire cost of each visit and service. The documentation is evaluated on a yearly basis. Each year you will be expected to submit your financial status for sliding fee scale eligibility per federal regulation.

SIGNATURE: _____ DATE:_____