



Patient Registration Form

Lower Lights Health is a Federally Qualified Health Center (FQHC) and 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!

Patient Demographic Information

Last Name

First Name

Date of Birth MM/DD/YY

SSN

Email (leave blank if none)

Address

City, State, Zip Code

Country

Home Phone

Cell/Work Phone

Legal Sex: ☐ Male ☐ Female ☐ Nonbinary

Gender Identity: ☐ Male ☐ Female ☐ Nonbinary ☐ Genderqueer ☐ Transgender - M ☐ Transgender - F

Sex Assigned at Birth: ☐ Male ☐ Female ☐ Intersex

Sexual Orientation: ☐ Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Queer ☐ Asexual
☐ Pansexual ☐ Unknown ☐ Choose not to disclose

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

Additional Information

Employment Status: ☐ Full Time ☐ Part Time ☐ Child ☐ Student ☐ Self Employed ☐ Not Employed

Language Spoken

Language Written

Interpreter Needed: ☐ Yes ☐ No

Homeless: ☐ Yes ☐ No ☐ Transitional

Migrant Worker: ☐ Yes ☐ No

Seasonal Worker: ☐ Yes ☐ No

Race: ☐ Black/African American ☐ White/Caucasian ☐ Native Hawaiian ☐ Asian Indian ☐ Native American
☐ Middle Eastern/North African ☐ Other Pacific Islander ☐ Other Asian ☐ Other: _____

Ethnicity: ☐ Mexican, Mexican American, or Chicano/a ☐ Cuban ☐ Non-Hispanic/Latino/a
☐ Another Hispanic/Latino/a or Spanish Origin ☐ Puerto Rican

Veteran/Military Status: ☐ Active Duty ☐ Inactive Duty ☐ Reservist ☐ Veteran ☐ No previous experience

Legal Guardian Information (for children under 18 years of age only)

First and Last Name

Phone Number

Emergency Contact

May we leave messages at your home with other residents? ☐ Yes ☐ No May we leave messages on your voicemail or answering machine? ☐ Yes ☐ No

Last Name

First Name

Date of Birth MM/DD/YY

Phone Number

Relationship to Patient

Patient Signature

Date



First and Last Name

Date of Birth MM/DD/YY

I do not want to apply for Financial Assistance.

☐

Address

I would like to apply for Medicaid and/or the
Sliding Scale Discount.

☐

Home Phone

Cell Phone

To retain our funding, we are required to collect the following information. This does NOT affect you or your household members in any way if you are not applying for financial assistance.

Monthly Gross Household Income : \$ _____

Avg. Hours Worked Per Week & Rate \$: _____

Family Size (number in household): _____

Household Members (First and Last Name) List all those you are financially responsible for.	Relationship to You (Circle One)	Date of Birth MM/DD/YY
	Self	
	Spouse / SO / Parent / Child / Other	
	Spouse / SO / Parent / Child / Other	
	Spouse / SO / Parent / Child / Other	
	Spouse / SO / Parent / Child / Other	
	Spouse / SO / Parent / Child / Other	
	Spouse / SO / Parent / Child / Other	
	Spouse / SO / Parent / Child / Other	
	Spouse / SO / Parent / Child / Other	
	Spouse / SO / Parent / Child / Other	

*Live in Ohio: Yes / No

*US Citizen: Yes / No

*Pregnant: Yes (Due Date: _____) No Not Applicable

By signing, I understand and agree to the following:

- Lower Lights Health can use this information to determine my poverty level.
- I must notify Lower Lights Health of any changes to my household's income or size or if insurance status changes.
- If applying for Sliding Scale Discount, payment is due at time of service.
- Attest that all information provided is true and accurate to best of my knowledge and belief.

Signature

Date



(For office use only.)

Patient Coverage:

☐

Medicaid

☐

Medicare

☐

Commercial Insurance

☐

No Coverage

☐

Income Verified

☐

No Income Verified

Initials

<i>Financial Determination:</i>	☐ Tier 1	☐ Tier 2	☐ Tier 3	☐ Over 200% FPL
Medical/Optical:	\$25	\$35	\$55	\$80
BH/Nutrition:	\$15	\$20	\$25	\$45
Dental:	\$40	\$60	\$80	\$95
Prenatal/Obstetrics:	\$15	\$20	\$25	\$30
Depo-Provera:	\$10	\$15	\$20	\$30
IUD-Liletta:	\$50	\$70	\$90	N/A
Pharmacy:	\$10	\$15	\$20	Retail Price

Effective Dates: _____ to _____

Proof of Income Attached: ☐ Yes ☐ No

If not attached, please explain:

Representative: _____

Date: _____



No Income Verification

I, (please print name) _____, declare that I am currently unemployed and my household is not receiving income from any source, including:

- Unemployment
- Disability
- SSI
- Pension
- Other household/family income

I agree that if my income status changes in any way, I will notify Lower Lights Health immediately at which time I will be required to complete a new Sliding Scale Discount Application and provide evidence of my household's income.

Patient Signature

Date

Employee Signature

Date

Title

Today's Date

Name

Date of Birth MM/DD/YY

Height

Weight

Home Phone

Cell/Work Phone

Current Medications (times/days)

Have you ever had the following, circle yes or no; leave blank if uncertain:

AID or HIV	Y / N	Diabetes	Y / N	Inflammatory Bowel Disease	Y / N
Anemia	Y / N	Enlarged Prostate	Y / N	Irritable Bowel Disease	Y / N
Angina	Y / N	Epilepsy	Y / N	Kidney Disease	Y / N
Atrial Fibrillation	Y / N	Gall Bladder Disease	Y / N	Migraines	Y / N
Asthma	Y / N	Heart Disease	Y / N	Pneumonia	Y / N
Blood Clots	Y / N	Heart Attack	Y / N	Polio	Y / N
Crohn's Disease	Y / N	Hepatitis Type:	Y / N	Rheumatic Fever	Y / N
Coronary Artery	Y / N	High Blood Pressure	Y / N	Stroke	Y / N
COPD	Y / N	High Cholesterol	Y / N	Thyroid Disease	Y / N
Cancer Type:	Y / N	Other:			

Please list any other health problems you have had:

Drug Allergies

Surgical history: Have you ever had the following surgeries? Please list the year received or leave blank if not applicable.

Procedure	Year	Procedure	Year	Procedure	Year
Appendectomy		Gastric Bypass		Mastectomy	
Angioplasty		Hernia Repair		Gall Bladder Surgery	
Heart Stent		Hip Replacement		Ovary Removal	
Arthroscopy Knee		Knee Replacement		Breast surgery	
Back Surgery		LASIK		Bowel Resection	
Blood Transfusion		Liver Biopsy		Tubal Ligation	
Carpal Tunnel Release		Pacemaker		Fibroid Surgery	
Coronary Bypass		Thyroid Surgery		ORIF	
Cataract Extraction		Tonsillectomy		Colostomy	
Colectomy		C-section			
D and C		Hysterectomy			

Hospitalizations: If you have been in the hospital overnight, state the year, illness/operation (do not include normal pregnancies):



Has any blood relatives had any of the following? (Circle Yes or No; leave blank if unsure)

Disease	Relationship	Disease	Relationship
ADD/ADHD		Irritable Bowel	
Alcohol Abuse		Learning Disability	
Allergies		Peripheral Vascular Disease	
Alzheimer's		Kidney Disease	
Blood Disorder		Migraines	

Disease	Age	Relationship	Cause of Death
Diabetes			
Stroke			
Heart Attack			
Coronary Artery Disease			
Development Delay		Genetic Disease	
Cancer (list type and relationship)			

For the following diseases, list the relationship and the age of onset, or whether it was the cause of death:

Disease	Age	Relationship	Cause of Death
Diabetes			
Stroke			
Heart Attack			
Coronary Artery Disease			

Social History:

Tobacco	Y / N	Packs per day:		Packs per year:	Y / N
Alcohol	Y / N	Drinks per week:		Type:	Y / N
Caffine	Y / N	Cups a day:		Type:	Y / N
Illegal Drugs	Y / N	Types			

Vaccines and health tests:

Vaccine or Test:	Year	Vaccine or Test:	Year	Vaccine or Test:	Year
Flu Vaccine		Tetanus Vaccine		Hepatitis Vaccine	
Pneumonia Vaccine		TB Test		Rubella Vaccine	
Stool Blood Test		Mammogram		Colonoscopy	
Eye Exam		PAP Smear			

For Women Only:

Age of first menstrual cycle		Date of Last Menstrual Cycle	
Use of Birth Control	Y / N	Type	
Number of Pregnancies		Number of Live Births	
Number of Full Term:		Number of Abortions	
Number of Premature		Number of Miscarriages:	