Lower Lights Health
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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 ☐ Seperated ☐ 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** _____

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Head of Household (UDS Form)

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

First and Last Name _____ Date of Birth MM/DD/YY _____

Address _____

Home Phone _____ Cell Phone _____

I do not want to apply for Financial Assistance. ☐

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

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

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Patient Agreement (Sliding Scale Discount Application)

(For office use only.)

Patient Coverage:

- ☐ Medicaid
- ☐ Medicare
- ☐ Commercial Insurance
- ☐ No Coverage

- ☐ Income Verified
- ☐ No Income Verified

_____
Initials

Financial Determination:	☐ 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:** _____

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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

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Health Questionnaire

To be completed by patient. Please print.

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 _____

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Health Questionnaire

To be completed by patient. Please print.

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):

_____

_____

_____

_____

_____

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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	
Alchohol 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			

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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:**	