Revised 10/1/2010

Application for Services - Good Neighbor Health Clinic & Red Logan Dental Clinic

70 North Main Street White River Jct VT 05001

Medical clinic phone: (802) 295-1868 Dental clinic phone: (802) 295-7573 Fax (802) 295-3600

Name _____ Patient Previous Name_____

Birthdate____/___/____ Age___ Gender _____ Social Security Number ____ - ____ -_____

Mailing Address _____

Town _____ State_____ Zip Code _____

Town of Residence, if different than mailing address: _____

Telephone: Home (____) _____ - _____ Cell(_____) ____ - _____ Work ( ) ____ - _____

Ok to call at work? Yes/No

If NO PHONE, give a message phone number (_____) _____ - _____ Whose phone? _____

Emergency Contact_____ Relationship_____ Phone Number _____

E-MAIL ADDRESS:

Number of Adults in the Household _____ Number of dependent children _____ **Household total:** _____

PLEASE ENCLOSE A COPY OF ANY INCOME WITH APPLICATION

Total Household Income (list income of all related adults in the household)

Patient Salary/Wages (before tax)	$ _____ per week	$ _____ per month
Spouse or Partner Salary/Wages (before tax)	$ _____ per week	$ _____ per month
Other income (public assistance or subsidies)	$ _____ per month	$ _____ per month
TOTAL Household Income (before tax)	**$_____ per week**	**_____ per month**

(Note: Monthly income equals weekly pay X 4.3 Example: $200 week X 4.3 = $860 month)

Do you have a savings account? ____ No _____ Yes, balance in the account: $_____

Marital Status: ____ Single ___Married ____Separated ____ Divorced

Employment Status: ___Full time ___Part Time ___Seasonal/Temp ___Self-Employed ___Unemployed

Are you a military Veteran? ____ Yes ____No **Do you smoke or chew tobacco?** ____ No ____ Yes

Education (# of years) _____ **Highest degree earned (high school, college)** _____

Do you have medical insurance? ____ No ____ Yes, what type_____

Do you have dental insurance? _____No _____Yes, what type _____

Do you have a Primary Care Provider (outside of the Good Neighbor Health Clinic)?_____No _____Yes

Have you delayed getting care because of the cost? ____ Yes ___No

Where would you go for medical/dental care if you couldn't come here? ___Emergency Dept. at hospital

_____ another doctor or dentist _____I wouldn't have gone ____ I don't know

I agree that the information provided on this form is accurate. I give Good Neighbor Health Clinic permission to verify information (including insurance status) contained on this form.

Signature _____ Date _____

(circle one: patient/parent/guardian)