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

PO Box 1250, White River Jct., VT 05001
Medical: (802) 295-1868 Dental: (802) 295-7573 June 2020

Name: ____ Previous Name: ____________________
(First) (Middle Initial) (Last)

Birthdate (Month/day/ year)**:** _____/_____/_____ Age: ________ Female ❑ Male ❑

Race: ____ **SSN:** ______-______-_______

Mailing Address: ____
Town: ____________________________ State: __________ Zip Code: _______________________

Physical Address: ____
Town: ____________________________ State: ___________ Zip Code: ______________________

Telephone: Home (_______): ________ - _________ Cell: (_____) ________- _______________

Email Address: ____

Where are you employed? ________________________________ Work phone (_____) _______-________
Ok to call at work? Yes ❑ No ❑

If no phone at work, give message phone #: (______) _____-________ whose phone? _________________

Emergency Contact: ____________________ Relationship: _____________ Phone (_____) _____-________

Household Children: How many dependent children under age 18 living at home? [ ]

Household Total: How many family members **total** are living in your household? [ ]
(You + spouse/partner + dependent children under age of 18 living at home)

Income: Household Income (before tax and withholding)	**Per Month:**
Your Income	$_____________
Spouse/Partner Income	$_____________
Other income (disability income, child support, or public assistance)	$_____________

Total household income (before tax): $_______________

Please attach Proof of Residency (driver's license or utility bill) and Proof of income (pay stub, W-2 or Social Security statement). This application is not complete without proof of income & residency.

Marital Status: Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑
Employment: Full time❑ Part Time❑ Seasonal/Temp ❑ Self-Employed❑ Unemployed ❑
Preferred Pharmacy ____
Education (# of years):________ highest degree earned (high school, college):______________________
Have you served in the Military? Yes ❑ No ❑
Do you have health insurance? Yes ❑ No ❑ if yes, what type? ______________________
Do you have dental insurance? Yes ❑ No ❑ if yes, what type? _______________________
Do you have a Primary Care Provider (outside of Good Neighbor Health Clinic)? Yes ❑ No ❑
Do you smoke or chew tobacco? Yes ❑ No ❑
Have you delayed getting care or medications because of the cost? Yes ❑ No ❑
Where would you go for medical care if you couldn't come here?
Emergency Dept at hospital ❑ Another doctor ❑ I wouldn't have gone ❑ I don't know ❑
How did you hear about us? ____

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

Signature: ____ **Date:** _________________________

Office ONLY: Chart #:____________ New Patient: _____ Updated Application_____ Date faxed for free care: _________