WELCOME! In your packet you will find an application for services and a medical history form.

In order to become a Red Logan Dental patient fully completed forms along with the indicated proofs attached will need to be mailed to our office. The income proofs are a month's worth of income proof for each wage earner in the household.

If you take any medications, please list them on the medical history form. If additional room is needed for this listing, you can list them on the back of the medical history form.

Please mail the completed forms back to Red Logan Dental Clinic in the enclosed self-addressed envelope. We cannot put you on our waitlist or schedule you for an appointment until we receive all necessary documents.

WHAT TO EXPECT NEXT

Once we have your application, we will review it, prioritize it, and put you on our wait list. We will contact you to schedule an appointment as soon as possible. We have many people waiting to come into the clinic, but we will do our best!

Every new patient can expect to have a complete oral evaluation with x-rays, a cleaning and restorative treatment.

Thank you,

Red Logan Staff
**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**

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**Name:**

(First)  (Middle Initial)  (Last)  

**Previous Name:** ______________________

**Birthdate** (Month/day/year): _____/_____/_____  

Age: ________  Female ☐  Male ☐

Race: ____________________________  

**SSN:** _____-____-_____

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**Mailing Address:**

Town: ____________________________  State: ________  Zip Code: ____________

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**Physical Address:**

Town: ____________________________  State: ________  Zip Code: ____________

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**Telephone:**  Home (_____): _______ - _______  Cell: (_____) _______ - _______

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**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? ____________________________

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**Emergency Contact:** ____________________  Relationship: ________  Phone (_____) _______ - _______.

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**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) [ ] ☐

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**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):** $__________

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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.

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

**Employment:** Full time ☐  Part Time ☐  Seasonal/Temp ☐  Self-Employed ☐  Unemployed ☐

**Preferred Pharmacy**

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**Education (# of years):** ________ highest degree earned (high school, college): __________________

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**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 ☐

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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 ☐

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**How did you hear about us?** __________________________

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*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: ________
Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication you may take can affect your oral health. Therefore, we need to know about some of your medical information.

- **Are you under a physician's care now?**
- **Have you ever been hospitalized or had a major operation?**
- **Have you ever had a serious head or neck injury?**
- **Are you taking any medications, pills, or drugs?**
- **Do you take, or have you taken, Phan-Fen or Redux?**
- **Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?**
- **Are you on a special diet?**
- **Do you use tobacco?**
- **Pregnant/Trying to get pregnant?**
- **Nursing?**
- **Taking oral contraceptives?**

**Are you allergic to any of the following?**
- **Aspirin**
- **Penicillin**
- **Metal**
- **Latex**
- **Codeine**
- **Sulfur Drugs**
- **Acrylic**
- **Local Anesthetics**
- **Do you use controlled substances?**
- **Other?**
- **If yes**

**Do you have, or have you had, any of the following?**
- **AIDS/HIV Positive**
- **Alzheimer's Disease**
- **Anaphylaxis**
- **Anemia**
- **Anemia**
- **Arthritis/Gout**
- **Artificial Heart Valve**
- **Artificial Joint**
- **Asthma**
- **Blood Disease**
- **Blood Transfusion**
- **Breathing Problems**
- **Bruise Easily**
- **Cancer**
- **Chemotherapy**
- **Chest Pains**
- **Cold Sores/Fever Blisters**
- **Congenital Heart Disorder**
- **Convulsions**
- **Yellow Jaundice**
- **Cortisone Medicine**
- **Diabetes**
- **Drug Addiction**
- **Easy Vindied**
- **Emphysema**
- **Epilepsy or Seizures**
- **Excessive Bleeding**
- **Excessive Thirst**
- **Fainting Spells/Dizziness**
- **Frequent Cough**
- **Frequent Diarrhea**
- **Frequent Headaches**
- **Genital Herpes**
- **Glaucoma**
- **Hay Fever**
- **Heart Attack/Failure**
- **Heart Murmur**
- **Heart Pacemaker**
- **Heart Trouble/Disease**
- **Hemophilia**
- **Hepatitis A**
- **Hepatitis B or C**
- **Hepatitis**
- **High Blood Pressure**
- **High Cholesterol**
- **Hives or Rash**
- **Hypoglycemia**
- **Irregular Heartbeat**
- **Kidney Problems**
- **Leukemia**
- **Liver Disease**
- **Low Blood Pressure**
- **Lung Disease**
- **Mental Valve Prostate**
- **Osteoporosis**
- **Pain in Jaw Joints**
- **Parathyroid Disease**
- **Psychiatric Care**
- **Radiation Treatments**
- **Recent Weight Loss**
- **Renal Dialysis**
- **Rheumatic Fever**
- **Rheumatism**
- **Scarlet Fever**
- **Shingles**
- **Sickle Cell Disease**
- **Sinus Trouble**
- **Spina Bifida**
- **Stomach/Intestinal Disease**
- **Stroke**
- **Swelling of Limbs**
- **Thyroid Disease**
- **Tonsillitis**
- **Tuberculosis**
- **Tumors or Growth**
- **Ulcers**
- **Venereal Disease**

**Have you ever had any serious illness not listed?**

**Comments:**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

**Signature of Patient, Parent or Guardian:**

X  

**Date:**