



Good Neighbor Health Clinics Red Logan Dental Clinic

Thank you for your interest in applying to be a patient at Red Logan Dental Clinic. Please read the following instructions closely before completing and returning all required documents.

HOW TO APPLY

In order to become a Red Logan Dental clinic patient you must fully complete and return **BOTH** forms that we provide:

- “Application for Services” form
- Medical History form
 - Please include your reason for seeking dental treatment in the “Comments” box at the bottom of the form

Additionally, your application is **NOT** complete without including:

- Proof of Income for **each** wage earner in your household
 - Ex. Pay stub, W-2, Social Security statement
- Proof of Residency for the patient
 - Ex. Driver’s license, utility bill
- List of Medications for the patient
 - This can be hand-written, typed, printed from a portal, etc.

You can send the documents listed above as a picture, PDF, or photocopy.

Please mail **completed application for services, completed medical history form, all proofs, and medication list** back to Red Logan Dental Clinic in the enclosed envelope. We cannot put you on our waitlist until we have received **ALL** necessary documents.

WHAT TO EXPECT NEXT

Once we have received your completed application, we will review it and put you on our waitlist. We will contact you to schedule an appointment as soon as possible. We have many people waiting to come into the clinic, but we do our best to accommodate new patients as our capacity allows.

We will attempt to contact everyone on the waitlist twice. **If we are unable to reach you after trying to call/contact you two times, you will be removed from the waitlist.** In that case, you will have to reapply in order to rejoin the waitlist.

Please note that we see patients from 9-12 and 1-4 on Mondays-Thursdays. We are unable to schedule appointments on evenings, Fridays, or weekends at this time.

At the first appointment, every new patient can expect to have a complete oral evaluation with X-rays to come up with a comprehensive plan for treatment. When you schedule your first appointment, please let us know if you have had any dental treatment (cleanings, fillings, extractions, etc.) and/or any dental x-rays taken within the past year.

Thank you,

Red Logan Staff

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

P.O. Box 1250, White River Junction VT 05001
Medical: (802) 295-1868 Dental: (802) 295-7573

January 2023

Name: _____ **Legal Name:** _____
(First) (Middle Initial) (Last) (If different)

Birthdate (Month/day/year): ____/____/____ **Age:** _____
Gender: Female Male Non-binary Intersex: Write in: _____

Race: _____ **SSN:** _____ - _____ - _____

Mailing Address: _____
Town: _____ State: _____ Zip Code: _____

Physical Address: _____
Town: _____ State: _____ Zip Code: _____

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

Email Address: _____
Are you employed? _____ Where? _____ Work phone (____) _____ - _____
Ok to call at work? Yes No

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):	\$ <input type="text"/>

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

Preferred Pharmacy: _____ **Location:** _____

Marital Status: Single Married Separated Divorced Widowed

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

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 could not 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:** _____

Patient Name:

Birth Date:

Date Created:

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

Are you under a physician's care now? Yes No If yes

Have you ever been hospitalized or had a major operation? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Are you taking any medications, pills, or drugs? Yes No If yes

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Do you use controlled substances? Yes No If yes

Other? If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No			

Have you ever had any serious illness not listed Yes No If yes

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: _____