Good Neighbor Health Clinic
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 (<u>before</u> 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), 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:** _____

Time 8:58 AM | Red Logan Dental Clinic | Date 7/24/2017

Eaglesoft Medical History

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