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**
Please refer to our website to see if we are accepting new patients. We may periodically stop accepting new patients in order to better take care of our current patients and patients on our waitlist.

In order to be considered for service, all of the following forms must be completed and returned:

- “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
- 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.
- Patient Responsibility notice
  - Each item must be initialed

You can send the documents listed above as a picture, PDF, or photocopy. Please mail your completed application packet, **including all of the above items**, 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 if you qualify. We will send you a letter to let you know whether or not you qualify to be placed on our waitlist. Once you are 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 three times. **If we are unable to reach you after trying to call/contact you three times, you will be removed from the waitlist.** In that case, you must reapply to be considered. If you need to cancel or reschedule your new patient appointment, we must know 24 hours prior. If you miss a new patient appointment, we will call you one time to reschedule. If you do not reschedule one week from our call, you will need to reapply.

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.
I am applying to the (check all that apply):  □ Dental Clinic  □ Medical Clinic  □ Eye Clinic

Patient Information
Title: □ Mr  □ Ms  □ Mrs  □ Mx  □ No title or N/A  □ Other: __________________________
Last Name: ___________________________ Legal First Name: ___________________________ Middle Initial: __________
Preferred name: ___________________________
DOB (month/day/year): __________/________/________ Age: __________ SSN: __________ - __________ - __________
Race: ___________________________ Languages spoken at home: ___________________________

Pronouns:  □ She/her  □ He/him  □ They/them  □ Prefer not to answer  □ Write in: __________

Gender:  □ Female  □ Male  □ Transgender  □ Genderqueer  □ Agender  □ Genderfluid  □ Unsure  □ Non-binary  □ Intersex  □ Prefer not to answer  □ Write in: __________

Sexual Identity (check all that apply):  □ Straight/Heterosexual  □ Lesbian/Gay/Homosexual  □ Bisexual  □ Pansexual  □ Polysexual  □ Queer  □ Asexual  □ Unsure  □ Prefer not to answer  □ Write in: __________

Gender Assigned at Birth:  □ Female  □ Male  □ Unsure  □ Intersex

Relationship Status:  □ Single  □ Married  □ Separated  □ Divorced  □ Widowed  □ In a relationship, not married  □ In relationship(s) with multiple partners

Relationship Structure:  □ Monogamous  □ Polyamorous  □ Non-monogamous/Open  □ Not in a relationship  □ Other: __________

Do you feel safe in your relationship? Yes□ No□ N/A□

Are you sexually active? Yes□ No□

Education and Employment Information

Highest Degree of Level of School Completed:
□ Less than high school diploma. Grade: ___  □ High school diploma or GED  □ Some college, but no degree  □ Associate’s Degree (such as AA, AS)  □ Bachelor’s Degree (such as BA, BS)  □ Master’s Degree, Professional Degree, or Doctorate (such as MA, MD, PhD)  □ Other: __________

Employment Status:
□ Full time  □ Part-time  □ Self Employed  □ Seasonal/Temp  □ Unemployed  □ Retired  □ Disabled
If employed, where? __________________________________ Work phone (____) _______ - ________
Is it okay for us to call you at work? Yes ☐ No ☐
Have you served in the Military? Yes ☐ No ☐ If yes, what branch? __________________________

**Housing Information**

Housing Status:  Rent ☐ Own ☐ Temporary Housing ☐ Unhoused ☐
Have you ever run out of food by the end of the month? Yes ☐ No ☐
Have you ever worried about running out of food? Yes ☐ No ☐
Mailing Address: ______________________________________________
                    Town: __________________________ State: __________ Zip Code: __________
Physical Address: _____________________________________________
                    Town: __________________________ State: __________ Zip Code: __________

**Contact Information**

Home phone: (______) _______ - ________; Cell: (_____) _______ - ________
Email Address: _______________________________________________
What is the best way for us to contact you? Home ☐ Cell ☐ Work ☐ Email ☐ Other: __________________________
Emergency Contact Name: _____________________________________ Relationship: ________________
Phone (______) _______ - ________

**Medical Information**

Preferred Pharmacy: __________________________________________ Location: __________________________
☐ Write in: __________________________
Do you have health insurance?
☐ Yes
☐ No
If yes, what type?
☐ Medicare
☐ VT Medicaid
☐ NH Medicaid

Do you have dental insurance?
☐ Yes
☐ No
If yes, what type?
☐ Medicare
☐ VT Medicaid
☐ NH Medicaid
☐ Write in: ________________________

Do you have a Primary Care Provider (outside of Good Neighbor Health Clinic)? Yes ☐ No ☐
If yes, please provide name of Provider: ________________________________

Do you smoke or chew tobacco? Yes ☐ No ☐ If yes, Smoke ☐ Chew ☐ Vape ☐
Are you interested in quitting smoking? 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?

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**Household Information**

**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)**

<table>
<thead>
<tr>
<th>Source</th>
<th>Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Income</td>
<td>$_________</td>
</tr>
<tr>
<td>Spouse/Partner Income</td>
<td>$_________</td>
</tr>
<tr>
<td>Other income (disability income, child support, or public assistance)</td>
<td>$_________</td>
</tr>
</tbody>
</table>

**Total household income (before tax)** $_________

This application is not complete without proof of income (Pay stub, W-2, Social Security Statement), proof of residency (driver’s license or utility bill), and medical history.

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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:** ________________
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

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>If Yes</th>
<th>If No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you under a physician’s care now?</td>
<td></td>
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<tr>
<td>Have you ever been hospitalized or had a major operation?</td>
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<tr>
<td>Have you ever had a serious head or neck injury?</td>
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<tr>
<td>Are you taking any medications, pills, or drugs?</td>
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<tr>
<td>Do you take, or have you taken, Phentol or Redux?</td>
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<tr>
<td>Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?</td>
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</tr>
<tr>
<td>Are you on a special diet?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you use tobacco?</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Women: Are you...

- [ ] 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?

- [ ] Yes
- [ ] No

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

- AIDS/HIV Positive
- Alzheimer’s Disease
- Anaphylaxis
- Anemia
- Angina
- Arthritis/Gout
- Artificial Heart Valve
- Artificial Joint
- Asthma
- Blood Disease
- Blood Transfusion
- Breathing Problems
- Bruise Easily
- Cancer
- Chemotherapy
- Chest Pains
- Cold Sores/Fever Blister
- Congenital Heart Disorder
- Convulsions
- Yellow Jaundice
- Cortisone Medicine
- Diabetes
- Drug Addiction
- Easily Winded
- Emphysema
- Epilepsy or Seizures
- Excessive Bleeding
- Excessive Thirst
- Fainting Spells/Dizziness
- Frequent Cough
- Frequent Diarrhea
- Frequent Headaches
- Genital Herpes
- Glaucoma
- Hay Fever
- Heart Failure
- Heart Murmur
- Heart Pacemaker
- Heart Trouble/Disease
- Hemophilia
- Hepatitis A
- Hepatitis B or C
- Herpes
- High Blood Pressure
- High Cholesterol
- Hives or Rash
- Hypoglycemia
- Irregular Heartbeat
- Kidney Problems
- Leukemia
- Liver Disease
- Low Blood Pressure
- Lung Disease
- Mitral Valve Prolapse
- Osteoporosis
- Osteoarthritis
- 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 Growths
- Ulcers
- Venereal Disease

Have you ever had any serious illness not listed?

- [ ] Yes
- [ ] No

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:________________