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

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.

Good Neighbor Health Clinic
Red Logan Dental Clinic

PO Box 1250
White River Junction, VT 05001
Phone: (802) 295-7573
Fax: (802) 359-1020
Website: www.goodnhc.org
Medical Clinic: medical@goodnhc.org
Dental Clinic: dental@goodnhc.org

July 2023

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 Assigned at Birth:
- ☐ Female
- ☐ Male
- ☐ Unsure
- ☐ Intersex

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: _____

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)

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?

_____

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)	**Per Month:**
Your Income	$_____
Spouse/Partner Income	$_____
Other income (disability income, child support, or public assistance)	$_____

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.

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:_____