Good Neighbor Health Clinic
Red Logan Dental Clinic

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

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

Patient Information

Title: ☐ Mr ☐ Ms ☐ Mrs ☐ Mx 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
- ☐ Write in: _____

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

Gender:
- ☐ Female
- ☐ Male
- ☐ Transgender
- ☐ Genderqueer
- ☐ Agender
- ☐ Genderfluid
- ☐ Unsure
- ☐ Non-binary
- ☐ Intersex
- ☐ Write in: _____

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

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
- ☐ Other: _____

Do you feel safe in your relationship? Yes ☐ No ☐

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**:** _____

Do you have health insurance?

☐ Yes

☐ No

If yes, what type?

☐ Medicare

☐ VT Medicaid

☐ NH Medicaid

☐ Write in: _____

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:** _____