Good Neighbor Health Clinic
Red Logan Dental Clinic

July 2023

PO Box 1250
White River Junction, VT 05001
Phone: (802) 295-1868
Fax: (802) 359-1020
Website: www.goodnhc.org
Medical Clinic: medical@goodnhc.org
Dental Clinic: dental@goodnhc.org

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

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: ______________

Patient Name: Birth Date: Date Created:

Question	Yes	No	If yes
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	If yes
Do you have mental health concerns?	Yes	No	If yes

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

Question	Yes	No	If yes
Do you use controlled substances?	Yes	No	If yes
Other?	Yes	No	If yes

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

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
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									

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

Comments. If yes above, please expand:

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:__________