



Good Neighbor Health Clinic Red Logan Dental Clinic

July 2023

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White River Junction, VT 05001
Phone: (802) 295-1868
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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:

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

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
Other: _____

Are you sexually active? Yes No

Education and Employment Information

Highest Degree or 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:

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

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?

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

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: _____