Good Neighbor Health Clinic
Red Logan Dental Clinic

July 2023

PO Box 1250
White River Junction, VT 05001
Phone: (802) 295-1868
Fax: (802) 295-3600
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:

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 ○ 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. 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:_____