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:** _____

Medical History Form

Patient Name: Date of Birth: Today's Date:

To the best of my knowledge, I will answer the questions on this form accurately. 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:

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 use tobacco?	☐ Yes	☐ No	If yes,
Do you use controlled substances?	☐ Yes	☐ No	If yes,

Are you…

☐ Pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Other? If yes,

Comments:

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

AIDS / HIV +	☐	Yes	☐	No	Cortisone Medicine	☐	Yes	☐	No	Hemophilia	☐	Yes	☐	No
Alzheimer's Disease	☐	Yes	☐	No	Diabetes	☐	Yes	☐	No	Hepatitis A	☐	Yes	☐	No
Anaphylaxis	☐	Yes	☐	No	Drug Addiction	☐	Yes	☐	No	Hepatitis B or C	☐	Yes	☐	No
Anemia	☐	Yes	☐	No	Easily Winded	☐	Yes	☐	No	Herpes	☐	Yes	☐	No
Angina	☐	Yes	☐	No	Emphysema	☐	Yes	☐	No	High Blood Pressure	☐	Yes	☐	No
Arthritis / Gout	☐	Yes	☐	No	Epilepsy or Seizures	☐	Yes	☐	No	High Cholesterol	☐	Yes	☐	No
Artificial Heart Valve	☐	Yes	☐	No	Excessive Bleeding	☐	Yes	☐	No	Hives or Rash	☐	Yes	☐	No
Artificial Joint	☐	Yes	☐	No	Excessive Thirst	☐	Yes	☐	No	Hypoglycemia	☐	Yes	☐	No
Asthma	☐	Yes	☐	No	Fainting Spells/Dizziness	☐	Yes	☐	No	Irregular Heartbeat	☐	Yes	☐	No
Blood Disease	☐	Yes	☐	No	Frequent Cough	☐	Yes	☐	No	Kidney Problems	☐	Yes	☐	No
Blood Transfusion	☐	Yes	☐	No	Frequent Diarrhea	☐	Yes	☐	No	Leukemia	☐	Yes	☐	No
Breathing Problems	☐	Yes	☐	No	Frequent Headaches	☐	Yes	☐	No	Liver Disease	☐	Yes	☐	No
Bruise Easily	☐	Yes	☐	No	Genital Herpes	☐	Yes	☐	No	Low Blood Pressure	☐	Yes	☐	No
Cancer	☐	Yes	☐	No	Glaucoma	☐	Yes	☐	No	Lung Disease	☐	Yes	☐	No
Chemotherapy	☐	Yes	☐	No	Hay Fever	☐	Yes	☐	No	Mitral Valve Prolapse	☐	Yes	☐	No
Chest Pains	☐	Yes	☐	No	Heart Attack / Failure	☐	Yes	☐	No	Osteoporosis	☐	Yes	☐	No
Cold Sores / Fever Blisters	☐	Yes	☐	No	Heart Murmur	☐	Yes	☐	No	Pain in Jaw Joints	☐	Yes	☐	No
Congenital Heart Disorder	☐	Yes	☐	No	Heart Pacemaker	☐	Yes	☐	No	Parathyroid Disease	☐	Yes	☐	No
Convulsions	☐	Yes	☐	No	Heart Trouble / Disease	☐	Yes	☐	No	Psychiatric Care	☐	Yes	☐	No
Yellow Jaundice	☐	Yes	☐	No										

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes,