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,

Good Neighbor Health Clinic
Red Logan Dental Clinic

PATIENT RESPONSIBILITY NOTICE

Effective January 1, 2026

*****Please read and initial the following*****

It is your responsibility as a patient of Good Neighbor Health Clinic and Red Logan Dental to:

1. **Keep ALL scheduled appointments -** If you cannot keep a scheduled appointment, you must inform us before the appointment as early as possible as there are others who also need appointments. _____

2. **Arrive 10 minutes early for appointments -** If you arrive 15 minutes or more after your scheduled appointment time, we will need to reschedule your appointment. _____

3. **Call and confirm your appointment -** We will give you a call one business days before your appointment. If we leave you a message, you must call us back to confirm. Unconfirmed appointments will be cancelled. _____

4. **Respect Staff.** You must treat all staff, visitors and the clinic property in a calm, respectful manner. Yelling, bad language, behavior that is disrespectful to staff or other patients and threats of any kind will not be tolerated and may result in the patient not being served. _____

3 missed appointments without 24-business hour notice will result in cancellation of all future appointments and you will be unable to make appointments for up to 6 months. Exceptions will be made at our discretion for illness, emergencies, etc.

We understand that true emergencies happen and those situations will be handled accordingly.