Good Neighbor Health Clinic
Red Logan Dental Clinic

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

June 2026

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 Positive	Yes ☐	No ☐	Cortisone Medicine	Yes ☐	No ☐
Alzheimer's Disease	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐
Anaphylaxis	Yes ☐	No ☐	Drug Addiction	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Easily Winded	Yes ☐	No ☐
Angina	Yes ☐	No ☐	Emphysema	Yes ☐	No ☐
Arthritis/Gout	Yes ☐	No ☐	Epilepsy or Seizures	Yes ☐	No ☐
Artificial Heart Valves	Yes ☐	No ☐	Excessive Bleeding	Yes ☐	No ☐
Artificial Joint	Yes ☐	No ☐	Excessive Thirst	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Fainting spells / Dizziness	Yes ☐	No ☐
Blood Disease	Yes ☐	No ☐	Frequent Cough	Yes ☐	No ☐
BIood Transfusion	Yes ☐	No ☐	Frequent Diarrhea	Yes ☐	No ☐
Breathing Problems	Yes ☐	No ☐	Frequent Headaches	Yes ☐	No ☐
Bruise Easily	Yes ☐	No ☐	Genital Herpes	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	Glaucoma	Yes ☐	No ☐
Chemotherapy	Yes ☐	No ☐	Hay Fever	Yes ☐	No ☐
Che.st Pains	Yes ☐	No ☐	Heart Attack/Failure:	Yes ☐	No ☐
Cold Sores/Fever Blisters	Yes ☐	No ☐	Heart Murmur	Yes ☐	No ☐
Congenital Heart Disorders	Yes ☐	No ☐	Heart Pacemaker	Yes ☐	No ☐
Convulsions	Yes ☐	No ☐	Heart Trouble/Disease	Yes ☐	No ☐
Yellow Jaundice	Yes ☐	No ☐			

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

Hemophilia	Yes ☐	No ☐	Radiation Treatments	Yes ☐	No ☐
Hepatitis A	Yes ☐	No ☐	Recent Weight Loss	Yes ☐	No ☐
Hepatitis B or C	Yes ☐	No ☐	Renal Dialysis	Yes ☐	No ☐
Herpes	Yes ☐	No ☐	Rheumatic Fever	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐	Rheumatism	Yes ☐	No ☐
High Cholesterol	Yes ☐	No ☐	Scarlet Fev.er	Yes ☐	No ☐
Hives or Rash	Yes ☐	No ☐	Shingles	Yes ☐	No ☐
Hypoglycemia	Yes ☐	No ☐	Sickle Cell Disease	Yes ☐	No ☐
Irregular Heartbeat	Yes ☐	No ☐	Sinus Trouble	Yes ☐	No ☐
Kidney Problems	Yes ☐	No ☐	Spina Bifida	Yes ☐	No ☐
Leukemia	Yes ☐	No ☐	Stomach/Intestinal Disease	Yes ☐	No ☐
Liver Disease	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Low Blood Pressure	Yes ☐	No ☐	Swelling of Limbs	Yes ☐	No ☐
Lung Disease	Yes ☐	No ☐	Thyroid Disease	Yes ☐	No ☐
MitraI Valve Prolapse	Yes ☐	No ☐	Tonsillitis	Yes ☐	No ☐
Osteoporosis	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐
Pain in Jaw Joints	Yes ☐	No ☐	Tumors or Growths	Yes ☐	No ☐
Parathyroid Disease	Yes ☐	No ☐	Ulcers	Yes ☐	No ☐
Psychiatric Care	Yes ☐	No ☐	Venereal Disease	Yes ☐	No ☐

Haveyou 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.

Good Neighbor Health Clinics

FREE CLINICS FEDERAL TORT CLAIMS ACT (FTCA) PROGRAM

Patient Notice of Limited Liability of

FTCA Deemed Volunteer Free Clinic Health Care Professionals

Malpractice coverage for the Good Neighbor Health Clinics is provided by the Federal Government

Details:

This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA), (See 28 U.S.C. §§ 1346(b), 2401(b), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by any free clinic volunteer health care practitioner who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. § 233(a), (o)). Certain free clinic health care professionals providing health care services to patients at this free clinic may be covered by the above Federal law.

Acknowledged:

_____(patient signature)

_____(patient name, printed legibly)

Date: _____

Telephone Consumer Protection Act (TCPA)

Agreement

Will you allow Good Neighbor to use an automated system to give you appointment reminder texts/calls before your appointments? If so, please read and sign below!

I _____ (or my guardian/legal representative) agree to be contacted by Good Neighbor Health Clinic (GNHC) and others on its behalf by telephone calls made by or using an automated dialing system or pre-recorded messages at the number(s) provided in this Application, for all non-marketing purposes. I (or my guardian/legal representative) agree to notify GNHC promptly if any of my numbers or addresses change in the future. I (or my guardian/legal representative) understand that this consent is not required, or a condition of purchase and it can be revoked at any time. By providing a phone number and signing below, I acknowledge that I have read and agree to the TCPA Communication Consent above.

☐ I agree to receive SMS/text reminders 24 hours prior to appointment (cell phones only)

☐ I agree to receive voice reminders 24 hours prior to appointment (voice will only be used as a fall-back if no cell # is on file or if SMS/text is failing)

Signature: _____

Date: _____

Approved: 4/9/24

Good Neighbor
Health Clinics

ACKNOWLEDGE RECEIPT OF PRIVACY PRACTICES

*You may refuse to sign this acknowledgement

I, _____, have seen and was offered a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____Individual refused to sign

____Communications barrier prohibited obtaining the acknowledgement

____An emergency situation prevented us from obtaining acknowledgement

____Other (Please Specify)

October 30, 2023

Good Neighbor Health Clinics

70 North Main Street

White River Junction, Vermont 05001

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect February ___, 2026 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information at the end of this notice.

Uses and Disclosures of Health Information

We use and disclose your health information for different purposes, including treatment and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and other performance, conducting training programs, accreditation, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses and disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

SUD Treatment Information. If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment or health care operations, we may use and disclose your Part 2 Program record for treatment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to perform their duties.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already acted in reliance on the authorization.

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice.

Disclosure Accounting: You have a right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full. If we do agree to additional restrictions, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location.

Amendment: You have the right to request that we amend or correct your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach: You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice: If you receive this Notice on our website or by electronic mail (email), you are entitled to receive this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure or your health information or to have us communicate with you by alternative means or alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officers: Elizabeth Franson, MHA

Telephone: 802-295-1868 Fax 802-295-3600

Email: Elizabeth@goodnhc.org

Address: PO Box 1250, White River Junction, VT 05001