Application for Services: Good Neighbor Health Clinic & Red Logan Dental Clinic

70 North Main Street, White River Junction VT 05001
Medical: (802) 295-1868 Dental: (802) 295-7573 Aug 2017

Name: _____ Previous Name: _____
(First) (Middle Initial) (Last)

Birthdate (Month/day/ year)**:** _____/_____/_____ Age: _____ Female ❑ Male ❑

Race: _____ **SSN:** _____-_____-_____

Mailing Address: _____
Town: _____ State: _____ Zip Code: _____

Physical Address: _____
Town: _____ State: _____ Zip Code: _____

Telephone: Home (_____): _____ - _____ Cell: (_____) _____- _____

Email Address: _____

Where are you employed? _____ Work phone (_____) _____-_____
Ok to call at work? Yes ❑ No ❑
If no phone at work, give message phone #: (_____) _____-_____ whose phone? _____

Emergency Contact: _____ Relationship: _____ Phone (_____) _____-_____

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 (<u>before</u> tax and withholding)	**Per Month:**
Your Income	$_____
Spouse/Partner Income	$_____
Other income (disability income, child support, or public assistance)	$_____
Total household income (before tax):	$_____

Please attach Proof of Residency (driver's license or utility bill) and Proof of income (pay stub, W-2 or Social Security statement). This application is not complete without proof of income & residency.

Marital Status: Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑
Employment: Full time❑ Part Time❑ Seasonal/Temp ❑ Self-Employed❑ Unemployed ❑
Preferred Pharmacy _____
Education (# of years):_____ highest degree earned (high school, college):_____
Have you served in the Military? Yes ☐ No ☐
Do you have health insurance? Yes ❑ No ❑ if yes, what type? _____
Do you have dental insurance? Yes ❑ No ❑ if yes, what type? _____
Do you have a Primary Care Provider (outside of Good Neighbor Health Clinic)? Yes ❑ No ❑
Do you smoke or chew tobacco? Yes ❑ No ❑
Have you delayed getting care or medications because of the cost? Yes ❑ No ❑
Where would you go for medical care if you couldn't come here?
Emergency Dept at hospital ❑ Another doctor ❑ I wouldn't have gone ❑ I don't know ❑
How did you hear about us? _____

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:** _____

Office ONLY: Chart #:_____ New Patient: _____ Updated Application_____ Date faxed for free care: _____

TIME 8:34 AM

Red Logan Dental Clinic

DATE 12/8/2009

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No _____
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Why have you come to the dentist today? WHAT DO you Need ?

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 _____ DATE _____