

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME / INITIAL	PREVIOUS NAME / NICKNAMES(S)
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SOCIAL SECURITY #	BIRTHDATE (MM/DD/YYYY)	EMAIL ADDRESS
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*While Shenandoah Community Health recognizes a number of gender sexes, many insurance companies and legal entities unfortunately do not. Please be aware that your legal name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different, please let us know.

BIRTH SEX (Circle One) Male Female Undifferentiated Unknown	CURRENT GENDER (Circle One) Male Female Undifferentiated	PREFERRED PRONOUN (Circle One) He, Him, His She, Her, Hers They, Them, Theirs Other Ze, Hir (Gender Free) Asked but unknown Decline to Answer
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GENDER IDENTITY <input type="checkbox"/> Male <input type="checkbox"/> Male-to-Female (MTF)/Transgender Female/Trans Woman <input type="checkbox"/> Female <input type="checkbox"/> Female-to-Male (FTM)/Transgender Male/Trans Man <input type="checkbox"/> Genderqueer, neither exclusively male nor female <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Additional gender category or other, please specify _____	SEXUAL ORIENTATION <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Don't Know <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Lesbian, gay, homosexual <input type="checkbox"/> Something else, please describe _____
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ADDRESS	CITY, STATE, ZIP	PHONE NUMBER
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BILLING ADDRESS (If Different Than Above)	CITY, STATE, ZIP	PREFERRED CONTACT METHOD
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MARITAL STATUS (Circle One) Single Married Widowed Divorced Legally Separated	PRIMARY LANGUAGE (Circle One) English Spanish American Sign Language Creole Haitian Creole Other: _____
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EMERGENCY CONTACT	NAME	TELEPHONE	RELATIONSHIP
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PREFERRED PHARMACY	PRIMARY CARE PROVIDER
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RESPONSIBLE PARTY INFORMATION (If Different Than Patient)

NAME (Last, First, Middle)	SSN#	BIRTHDATE
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ADDRESS	CITY, STATE, ZIP	TELEPHONE
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RELATIONSHIP TO PATIENT

HOUSING STATUS <input type="checkbox"/> Doubling Up <input type="checkbox"/> Not Homeless <input type="checkbox"/> Shelter <input type="checkbox"/> Street <input type="checkbox"/> Transitional	RACE <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> More Than One Race <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other: _____
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MIGRANT WORKER STATUS <input type="checkbox"/> Migrant <input type="checkbox"/> Not A Farmworker <input type="checkbox"/> Seasonal	ETHNICITY <input type="checkbox"/> Not Hispanic Or Latino <input type="checkbox"/> Hispanic Or Latino <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican <input type="checkbox"/> Dominican <input type="checkbox"/> Guatemalan <input type="checkbox"/> Haitian <input type="checkbox"/> Honduran <input type="checkbox"/> Jamaican <input type="checkbox"/> Venezuelan <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Latin American <input type="checkbox"/> Mexican American <input type="checkbox"/> Other: _____
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LANGAUGE BARRIER (Circle One) YES NO	ARE YOU A MILITARY SERVICE VETERAN? (Circle One) YES NO
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PLEASE SHOW ALL INSURANCE CARDS TO THE RECEPTIONIST

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		MEMBER / SUBSCRIBER ID #	
		GROUP #	
ADDRESS OF INSURANCE COMPANY		CITY, STATE, ZIP	
NAME OF INSURED (EMPLOYEE, IF THROUGH WORK)		RELATIONSHIP OF PATIENT TO INSURED	
INSURED DATE OF BIRTH	COPAY AMOUNT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (If Applicable)

NAME OF INSURANCE COMPANY		MEMBER / SUBSCRIBER ID #	
		GROUP #	
ADDRESS OF INSURANCE COMPANY		CITY, STATE, ZIP	
NAME OF INSURED		RELATIONSHIP TO PATIENT	
INSURED DATE OF BIRTH	COPAY AMOUNT	EFFECTIVE DATE	EXPIRATION DATE

We are required by funding agencies to obtain the following information from our patients for statistical purposes. This will help us secure grants to support outreach and programs for patients with special needs. Your individual information remains private and confidential and is not shared with any agency or organization.

BASED UPON YOUR FAMILY SIZE AND ANNUAL FAMILY INCOME, WHICH COLUMN FROM THE CHART BELOW WOULD BEST FIT YOUR FINANCIAL SITUATION?

Example: family size of 3 with annual family income of \$25,000, circle column letter B

CIRCLE ONLY THE LETTER OF THE COLUMN : A B C D

FAMILY SIZE	ANNUAL FAMILY INCOME			
	A	B	C	D
1	\$12,490 or less	\$12,491 - \$18,735	\$18,735- \$24,980	More than \$24,981
2	\$16,910 or less	\$16,911 - \$25,365	\$25,366 - \$33,820	More than \$33,821
3	\$21,330 or less	\$21,331 - \$31,995	\$31,996 - \$42,660	More than \$42,661
4	\$25,750 or less	\$25,751 - \$38,625	\$38,626 - \$51,500	More than \$51,501
5	\$30,170 or less	\$30,171 - \$45,255	\$45,256 - \$60,340	More than \$60,341
6	\$34,590 or less	\$34,591 - \$51,885	\$51,886 - \$69,180	More than \$69,181
7	\$39,010 or less	\$39,011 - \$58,515	\$58,516 - \$78,020	More than \$78,021
8	\$43,430 or less	\$43,431 - \$65,145	\$65,146 - \$86,860	More than \$86,861

SIGN _____ **DATE** _____



Shenandoah Valley Medical System, Inc. does business as Shenandoah Community Health (SCH). This health center receives Health and Human Services funding and has Federal Public Health Service deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals. SCH is an equal opportunity provider, serving all patients regardless of ability to pay.



HEALTHY SMILES COMMUNITY ORAL HEALTH CENTER OF SHENANDOAH COMMUNITY HEALTH

Pre-medical Screening

Name: _____ DOB: _____

Reason for being seen: _____

1. List all medications you are currently taking and the name of the doctor prescribing:

Medication	Dose	How Often?	Who Prescribed?

2. Check over-the-counter medications taken:

- | | | | |
|---------------------------------------|--|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Antacids | <input type="checkbox"/> Allergy Relief Medicine | <input type="checkbox"/> Herbal Remedies/ Supplements |
| <input type="checkbox"/> Tylenol | <input type="checkbox"/> Laxatives | <input type="checkbox"/> Sleep Medicine | <input type="checkbox"/> Weight Loss Aids |
| <input type="checkbox"/> Excedrin | <input type="checkbox"/> Sinus Relief Medicine | | <input type="checkbox"/> Muscle/ Weight gain aids |
| <input type="checkbox"/> Other: _____ | | | |

3. List all allergies, including allergies to medication:

4. Do you smoke?

Yes No

How much? _____

How Long? _____

5. Do you drink alcoholic beverages?

Yes No

How much? _____

6. Do you use marijuana or other drugs?

Yes No

Which drug(s)? _____



HEALTHY SMILES COMMUNITY ORAL HEALTH CENTER OF SHENANDOAH COMMUNITY HEALTH

DATE COMPLETED: _____

PATIENT NAME: _____ BIRTH DATE: _____

Primary Medical Insurance Coverage? Yes No If yes, please explain: _____

Primary Care Physician Name and Phone Number: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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 on a special diet? Yes No

Women: Are You: Pregnant Trying to get pregnant Nursing Taking oral contraceptives

All Patients: Do you have, or have you had, any of the following?

- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Cold Sores/ Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack/ Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/ Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/ Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart trouble/ Disease | <input type="checkbox"/> Pain in jaw joints | <input type="checkbox"/> Swelling of limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Aspersers disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Fainting spells/ Dizziness | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or rash | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Chemotherapy | | | | |

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

Comments: _____

Emergency Contact Name: _____ Phone: _____

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 LEGAL GUARDIAN: _____

DATE: _____



LATE ARRIVAL / CANCELTION / NO SHOW

We do our very best to stay on schedule. We also understand that from time to time an emergency will arise and you may be late or miss an appointment.

We reserve the right to reschedule patients if they are not on time for their appointment. Please call if you are running late.

Please give 24 hour notice to cancel or reschedule an appointment. An appointment not cancelled with 24 hour notice is considered a no show appointment.

We do have a strict no show policy. The **FIRST** broken appointment, **NO** new appointments will be given within 2 weeks. The **SECOND** broken appointment, **NO** new appointments will be given within 4 weeks. The **THIRD** broken appointment, **ONLY** same day appointments will be given.

PARENT / LEGAL GUARDIAN

All children must be accompanied by a parent or legal guardian (with court papers) for each visit and remain present during the entire appointment.

In order to allow another adult to bring your child to the appointment they must be listed on the consent form.

If the adult accompanying you child is not on the consent form they must provide a note with the following information: name and birth date of the child, name of adult accompanying the child, any current medical conditions or medications, consent for treatment being provided that day and the signature and phone number of the parent and today's date.

ACCOMPANYING CHILDREN TO EXAM ROOMS

We would like to continue to offer the parents of our patients the privilege to accompany their children to our child friendly operatories during their dental visit. In order to continue this offer we need the parent/guardian to follow these procedures:

It is necessary to ask that only **ONE** adult accompany their child to the clinical area.

All siblings of patients must remain in the waiting area with accompanying adult. Children under the age of 11 are unable to remain in waiting are without adult supervision.

For the protection of your child and our staff, we are unable to watch your children during scheduled appointments.

Adults cannot have children in the operatories while they are being treated.

If the patient should become uncooperative at any time during treatment, and the provider feels it would be in the best interest of the patient, it may be necessary to ask the parent to be seated in the waiting area for the remainder of the appointment.

Restorative appointments- Only one parent is allowed to accompany child to operatory until treatment begins. Once treatment begins we will ask all parents remain in the waiting area.

SIBLING APPOINTMENT

Due to the number of no show and broken appointments we will no longer be scheduling more than two siblings together in one day.

If we are scheduling more than one sibling, they must be able to be alone in the exam room.

If you wish to accompany your child to the exam room you must have a second adult over the age of 18 to remain in the waiting room with the sibling while you are in the exam room.

Patient or Parent/ **Guardian** signature

Date

Print Patient Name: _____





Consents

I hereby give consent for myself to receive the services of Shenandoah Valley Medical System, Inc. that does business as Shenandoah Community Health.

I understand that I am responsible for contacting the office at least 48 hours in advance if I am unable to keep my scheduled appointment.

I acknowledge that I have received Shenandoah Community Health’s “*Joint Notice of Privacy Practices*” for protected health information.

I authorize staff of Shenandoah Community Health (SCH) to take my picture or scan my photo ID and place it in my Electronic Medical Record for purposes of identification. I understand that this photograph will be protected as part of my medical record and unless otherwise required by federal or state law as noted in the SCH “*Joint Notice of Privacy Practices*”, will not be released without my written authorization.

During the course of care and treatment I understand that various types of examinations, tests, diagnostics or procedures may be necessary. This may include, but is not limited to, hearing and/or vision screening, laboratory testing, urine drug screening, injections, and other testing that the provider deems necessary. If I have any questions concerning these procedures, I will ask my clinician to provide me with additional information. I also understand my provider may ask me to sign additional Informed Consent documents related to specific procedures.

I authorized payment of insurance benefits to Shenandoah Valley Medical System, Inc. for medical services rendered to me. I understand that I am responsible for payment of fees for medical services rendered to me that are not covered by insurance or other third party payers, including copay, deductible and non-covered amounts.

If the client is a minor, a parent/legal guardian is aware and consent to this treatment.

Patient Name

Date of Birth

Parent or Legal Guardian Signature (if patient is a minor)

Date

Witness

Date





HEALTHY SMILES COMMUNITY ORAL HEALTH CENTER OF SHENANDOAH COMMUNITY HEALTH Medical Consent Form for Minor

Date: _____

First Name of Child

Last Name of Child

Date of Birth

Parent's Name & Address & Phone Number

We hereby appoint:

Name: _____

Relation to Child: _____

Address: _____

Telephone: _____

As the person who during my/our absence, shall be authorized to consent for all medical and/or surgical treatment and immunizations, diagnostic tests, etc.; which may be required during our absence without any manner limiting the foregoing appointment and authorization. **This form is good for one year unless revoked in writing.**

Name of Physician/Telephone: _____

List allergies and current medications, if any:

Shenandoah Valley Medical System, Inc., which does business as Shenandoah Community Health, its officers and personnel and any physician providing care authorized by the above named to act as appointee with the same force and effect as if personally executed by us. The consent and authorization shall include and extend to all matters for which consent or authorization is required under the policies in consideration of the services, which are rendered to any child above. Pursuant hereto, we agree to pay for all services.

Parent Signature

Parent Signature

In the event that only one parent executes this form, please state below the reason why the signature of the other parent cannot be obtained: _____

