SCH
Shenandoah
Community Health

## PATIENT INFORMATION

| LAST NAME | FIRST NAME | MIDDLE NAME / INITIAL | PREVIOUS NAME / NICKNAMES(S) |
|---|---|---|---|
| | | | |

| SOCIAL SECURITY # | BIRTHDATE (MM/DD/YYYY) | EMAIL ADDRESS |
|---|---|---|
| | | |

*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) | CURRENT GENDER (Circle One) | PREFERRED PRONOUN (Circle One) |
|---|---|---|
| Male Female | Male Female | He, Him, His She, Her, Hers They, Them, Theirs Other |
| Undifferentiated Unknown | Undifferentiated | Ze, Hir (Gender Free) Asked but unknown Decline to Answer |

| GENDER IDENTITY | SEXUAL ORIENTATION |
|---|---|
| ☐ Male ☐ Male-to-Female (MTF)/Transgender Female/Trans Woman | ☐ Choose not to disclose ☐ Don't Know |
| ☐ Female ☐ Female-to-Male (FTM)/Transgender Male/Trans Man | ☐ Straight or heterosexual ☐ Bisexual |
| ☐ Genderqueer, neither exclusively male nor female ☐Choose not to disclose | ☐ Lesbian, gay, homosexual |
| ☐ Additional gender category or other, please specify _____ | ☐ Something else, please describe _____ |

| ADDRESS | CITY, STATE, ZIP | PHONE NUMBER |
|---|---|---|
| | | |

| BILLING ADDRESS (If Different Than Above) | CITY,STATE,ZIP | PREFERRED CONTACT METHOD |
|---|---|---|
| | | |

| MARITAL STATUS (Circle One) | PRIMARY LANGUAGE (Circle One) |
|---|---|
| Single Married Widowed | English Spanish American Sign Language Creole Haitian Creole |
| Divorced Legally Separated | Other:_____ |

| EMERGENCY CONTACT NAME | TELEPHONE | RELATIONSHIP |
|---|---|---|
| | | |

| PREFERRED PHARMACY | PRIMARY CARE PROVIDER |
|---|---|
| | |

## RESPONSIBLE PARTY INFORMATION (If Different Than Patient)

| NAME (Last, First, Middle) | SSN# | BIRTHDATE |
|---|---|---|
| | | |

| ADDRESS | CITY, STATE, ZIP | TELEPHONE |
|---|---|---|
| | | |

RELATIONSHIP TO PATIENT

| HOUSING STATUS | RACE |
|---|---|
| ☐ Doubling Up ☐ Not Homeless | ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ More Than One Race |
| ☐ Shelter ☐ Street | ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White |
| ☐ Transitional | ☐ Other: _____ |
| MIGRANT WORKER STATUS | ETHNICITY |
| ☐ Migrant | ☐ Not Hispanic Or Latino ☐ Hispanic Or Latino ☐ Cuban ☐ Mexican ☐ Dominican |
| ☐ Not A Farmworker | ☐ Guatemalan ☐ Haitian ☐ Honduran ☐ Jamaican ☐ Venezuelan ☐ Puerto Rican |
| ☐ Seasonal | ☐ Latin American ☐ Mexican American ☐ Other: _____ |
| LANGAUGE BARRIER (Circle One) | ARE YOU A MILITARY SERVICE VETERAN? (Circle One) |
| YES NO | YES NO |

Over ➡

**PLEASE SHOW ALL INSURANCE CARDS TO THE RECEPTIONIST**

| PRIMARY INSURANCE | | | |
|---|---|---|---|
| NAME OF INSURANCE COMPANY | | MEMBER / SUBSCRIBER ID #<br>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 #<br>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** _____

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# Health Information

Name: _____ Date of Birth:_____

What type of work do you do?_____

When was your last immunization for:
Tetanus_____/_____/_____Pneumonia_____/_____/_____Influenza (Flu) _____/_____/_____

**Women:**
Have you ever been sexually active? Yes / No
Are you currently sexually active? Yes / No
Number of pregnancies:_____
Age first pregnancy:_____
Number of full term births:_____
Number of preterm births:_____
Number of abortions:_____
Number of miscarriages:_____
Number of ectopic pregnancies:_____
Number of living children:_____
Date of your last mammogram_____/_____/_____

Number of Cesarean sections:_____
Number of vaginal deliveries:_____
Complications:_____
Current birth control method_____
If Birth Control Pill, name the type:_____
Any problems?_____
First day of Last Menstrual Period_____/_____/_____
Date of your last Pap Test____/____/____Normal? Yes / No
Have you had a hysterectomy? Yes / No
Are you Pre/Post Menopausal? Yes / No

Date of your last colonoscopy _____/_____/_____

**Men:**
Have you ever been sexually active? Yes / No
Are you currently sexually active? Yes / No

Do you check your testicles monthly? Yes / No
Date of your last colonoscopy _____/_____/_____

**Children:**
Any problems during mother's pregnancy?_____ Birth weight?_____
Any problems during labor/delivery?_____
**Please bring a copy of the child's immunization record*

**All:**
Are you exposed to physical or emotional abuse? Yes / No
Are you exposed to any domestic violence? Yes / No
Do you need assistance with walking? Yes / No
Do you wear glasses/contact lenses? Yes / No
Do you wear hearing aids? Yes / No
Do you need assistance reading? Yes / No
Do you need assistance writing? Yes / No
Did someone help you complete this form? Yes / No
Do you have any cultural/religious beliefs that effect your care? Yes / No
What is your preferred learning method? *(Please circle one)*
Audio Materials / Demonstration / Verbal Explanation / Video Material / Written Material
Do you have Advanced Directives completed? Yes / No
Do you have smoke detectors in your home? Yes / No
Do you have any guns in your house? Yes / No

What medications do you take? Include prescription, over-the-counter, and herbal supplements:_____
_____
_____
_____
Are you allergic to any medications, anesthetics (numbing medicines), iodine, latex, tape, or foods, anything else? Yes / No
_____
_____

Name: _____ Date of Birth:_____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

| | Not At All | Several Days | More Than Half the Days | Nearly Every Day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed or hopeless | 0 | 1 | 2 | 3 |

Have you ever been hospitalized overnight? Yes / No When and for what reason?_____
Have you ever had surgery? Yes / No When and for what reason?_____

Do you have any current or past medical conditions such as: *(Please circle)*

Headaches
Back Trouble
Ulcers
Trouble swallowing
Arthritis
Anemia
Heart Trouble (Chest Pain, Irregular Heartbeat)
Hepatitis
Stroke
High Blood Pressure
Broken Bones
Asthma
Emphysema
Diabetes
Pneumonia
Tuberculosis
Drug or Alcohol Addiction
Heartburn
Hearing difficulty
HIV
Bowel Trouble
Diarrhea
Infertility
Constipation
Urinary Problems (Infection, Loss of Bladder Control)
Breast Problems
Cancer
Thyroid Problems
Sexual Problems
Back Trouble
Seizures
Mental Health Issues (Depression, Anxiety, Stress)
Vision problems (Blurry Vision, Glaucoma, Cataracts)
Other:_____
_____

Does anyone in your family (children, parents, and siblings) have a history of: (If so, please state who)

Asthma/COPD_____
Cancer_____
Diabetes_____
Drug/Alcohol Addiction_____
Heart Issues_____
Other:_____
High Blood Pressure_____
Mental Health Issues_____
Stroke_____
Thyroid Issue_____

Do you smoke or use tobacco? Yes/No How much per day? _____ Do you live with someone who smokes? Yes / No
Do you vape? Yes / No How much per day? _____
How much alcohol do you drink per day?_____
How much caffeine do you drink per day?_____
Do you use marijuana or other drugs? Yes / No Which drugs? _____

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# 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 |

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# Authorization to Discuss

I authorize Shenandoah Community Health Center to discuss my health information with the following:

1.) Name _____
Phone_____
Relationship_____

2.) Name _____
Phone _____
Relationship_____

This **does not include** information regarding substance abuse treatment, HIV or mental health treatment unless specifically granted below by **initialing** next to each item to be discussed.

_____Substance Abuse Treatment

_____HIV Treatment

_____Mental Health Treatment

_____Child Abuse and/or Domestic Abuse history

_____STD Treatment

This authorization is valid for one year from the date signed unless revoked by me in writing. I am not required to sign this authorization. It is my responsibility to notify Shenandoah Community Health Center of any changes to contacts or phone numbers. Shenandoah Community Health Center does not condition treatment, payment, or benefit eligibility on signing of this form.

**Patient Name _____**
**Date of Birth_____**
**Phone #_____**

**Signature_____**
**Relationship / Legal Authorization if not Patient_____**
**Date_____**