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 # 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	$12,140 or less	$12,141 - $18,210	$18,211- $24,280	More than $24,281
2	$16,460 or less	$16,461 - $24,690	$24,691 - $32,920	More than $32,921
3	$20,780 or less	$20,781 - $31,170	$31,171 - $41,560	More than $41,561
4	$25,100 or less	$25,101 - $37,650	$37,651 - $50,200	More than $50,201
5	$29,420 or less	$29,421 - $44,130	$43,131 - $58,840	More than $58,841
6	$33,740 or less	$33,741 - $50,610	$50,611 - $67,480	More than $67,481
7	$38,060 or less	$38,061 - $57,090	$57,091 - $76,120	More than $76,121
8	$42,380 or less	$42,381 - $63,570	$63,571 - $84,760	More than $84,761

SIGN _____ **DATE** _____

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:
   - ☐ Aspirin ☐ Antacids ☐ Allergy Relief Medicine ☐ Herbal Remedies/ Supplements
   - ☐ Tylenol ☐ Laxatives ☐ Sleep Medicine ☐ Weight Loss Aids
   - ☐ Excedrin ☐ Sinus Relief Medicine ☐ Muscle/ Weight gain aids
   - ☐ Other:_____

3. List all allegies, 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

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

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?

❑AIDS/HIV Positive	❑Chest pains	❑Frequent Headaches	❑Irregular Heartbeat	❑Scarlet Fever
❑Alzheimer's disease	❑Cold Sores/ Fever Blisters	❑Genital Herpes	❑Kidney Problems	❑Shingles
❑Anaphylaxis	❑Congenital Heart disease	❑Glaucoma	❑Leukemia	❑Sickle Cell Disease
❑Anemia	❑Convulsions	❑Hay Fever	❑Liver Disease	❑Sinus Trouble
❑Angina	❑Cortisone Medicine	❑Heart Attack/ Failure	❑Low Blood Pressure	❑Spina Bifida
❑Arthritis/ Gout	❑Diabetes	❑Heart Murmur	❑Lung Disease	❑0Stomach/ Intestinal
Disease				
❑Artificial Heart Valve	❑Drug Addiction	❑Heart Pace Maker	❑Mitral Valve Prolapse	❑Stroke
❑Artificial Joint	❑Easily Winded	❑Heart trouble/ Disease	❑Pain in jaw joints	❑Swelling of limbs
❑Asthma	❑Emphysema	❑Hemophilia	❑Parathyroid disease	❑Thyroid Disease
❑Blood disease	❑Epilepsy or Seizures	❑Hepatitis A	❑Psychiatric Care	❑Tonsillitis
❑Blood Transfusion	❑Excessive Bleeding	❑Hepatitis B or C	❑Radiation Treatments	❑Tuberculosis
❑Breathing Problem	❑Excessive thirst	❑Herpes	❑Recent Weight Loss	❑Tumors or Growths
❑Bruise Easily	❑Fainting spells/ Dizziness	❑High blood pressure	❑Renal Dialysis	❑Ulcers
❑Cancer	❑Frequent Cough	❑Hives or rash	❑Rheumatic Fever	❑Venereal Disease
❑Chemotherapy	❑Frequent Diarrhea	❑Hypoglycemia	❑Rheumatism	❑Yellow Jaundice

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.

HEALTHY SMILES COMMUNITY ORAL HEALTH CENTER
OF SHENANDOAH COMMUNITY HEALTH

LATE ARRIVAL / CANCELATION / 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: _____

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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

Nitrous Oxide Informed Consent

Nitrous oxide (most often called "laughing gas") is a colorless gas during dental treatments for relaxation. It can reduce anxiety, fear, and any apprehensions that a patient may have. It is a safe mixture of gas/ oxygen which is inhaled by a nasal mask. It takes effect in a few minutes and is completely eliminated from the body following the end of its administration, when flushed with pure oxygen.

During use of nitrous oxide, a patient may have feelings that include, but are not excluse of: tingling in the fingers or toes; heaviness in the thighs and/ or legs; warm feeling throughout entire body; fits of uncontrollable laughter or giddiness; detachment or disassociation from environment; lightweight or floating sensation; sluggishness in motion or slurring of words; feeling of nausea and/ or vomiting.

Using nitrous oxide during dental treatments is a very safe and effective technique. The patient will remain fully conscious and will be able to respond to direction. Any additional questions/ concerns, please feel free to ask the dental provider at time of treatment.

_____ _____

Patient or Parent/ **Guardian** signature Date

Print Patient Name: _____

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Consentimientos

Por la presente, doy consentimiento para que yo mismo o mi hijo recibamos los servicios de *Shenandoah Valley Medical System, Inc.*, que opera como *Shenandoah Community Health*.

Si no puedo concurrir a mi cita, entiendo que tengo la responsabilidad de contactar a la oficina con por lo menos 48 horas de anticipación.

Acuso recibo del *"Aviso Conjunto de Privacidad"* de *Shenandoah Community Health* referente a la protección de información médica.

Autorizo al personal de *Shenandoah Community Health (SCH)* a que, con fines de identificación, tomen mi foto o escaneen mi documento de identidad con foto y lo coloquen en mi Registro Médico Electrónico. Entiendo que esta fotografía será protegida como siendo parte de mi registro médico y, a no ser que sea requerido por leyes federales o estatales, de acuerdo con el *"Aviso Conjunto de Privacidad"* de SCH, la misma no será divulgada sin mi autorización por escrito.

Durante el transcurso de mis cuidados y tratamientos, puede ser necesario que se realicen varios tipos de exámenes, análisis, diagnósticos o procedimientos. Los mismos pueden incluir, pero no se limitan a, revisión de la audición y/o la vista, análisis de laboratorio, prueba de orina para detección de sustancias controladas, inyecciones, u otros análisis, los cuales el proveedor médico considere necesarios. Si tengo alguna pregunta relacionada con estos procedimientos le pediré a mi médico clínico que me otorgue más información. También entiendo que mi proveedor médico puede pedirme que firme otros documentos de Consentimiento Informado relacionados con procedimientos específicos.

Autorizo el pago de beneficios de los seguros médicos a Shenandoah Valley Medical System, Inc. por los servicios médicos que me hayan prestado que soy responsable de pagar las tarifas de los servicios médicos que no estén cubiertos por el seguro medico o por terceros, incluyendo los co-pagos, deducibles y otros montos no cubiertos.

Si el cliente es menor de edad, un padre/tutor legal es consciente y da consentimiento para la realización de este tratamiento.

_____	_____
Nombre del Pacient	Fecha de Nacimiento
_____	_____
Firma del Pacient/Representante legal	Fecha
_____	_____
Testigo	Fecha