SCH
Shenandoah
Community Health®

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME / INITIAL	PREVIOUS NAME / PREFERRED NAME

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 ☐ Transgender Male/Female-to-Male ☐ Other	☐ Lesbian or Gay ☐ Don't Know
☐ Female ☐ Transgender Female/Male-to-Female	☐ Straight (not lesbian or gay) ☐ Choose not to disclose
☐ Non-binary ☐ Choose not to disclose	☐ Bisexual ☐ Something else, please describe _____

PHYSICAL 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

HOUSING STATUS	RACE
☐ Not Homeless ☐ Doubling Up	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian
☐ Transitional ☐ Shelter	☐ Other Pacific Islander ☐ White ☐ Other: _____
☐ Street	

MIGRANT WORKER STATUS	ETHNICITY
☐ Migrant ☐ Seasonal	☐ Not Hispanic Or Latino ☐ Hispanic Or Latino

LANGAUGE BARRIER (Circle One)	ARE YOU A MILITARY SERVICE VETERAN? (Circle One)
YES NO	YES NO

CHIEF COMPLAINT/REASON FOR VISIT

REFERRAL SOURCE

Over

HOUSEHOLD SIZE AND ANNUAL FAMILY INCOME	
FAMILY SIZE: _____	**ANNUAL FAMILY INCOME: $_____**

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.

RESPONSIBLE PARTY INFORMATION (If Different Than Patient)		
NAME (Last, First, Middle)	SSN#	BIRTHDATE
ADDRESS	CITY, STATE, ZIP	TELEPHONE
RELATIONSHIP TO PATIENT		

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

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

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?

❑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	❑Stomach/ 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
❑Aspersers disease	❑Epilepsy or Seizures	❑Hepatitis A	❑Psychiatric Care	❑Tonsillitis
❑Blood disease	❑Excessive Bleeding	❑Hepatitis B or C	❑Radiation Treatments	❑Tuberculosis
❑Blood Transfusion	❑Excessive thirst	❑Herpes	❑Recent Weight Loss	❑Tumors or Growths
❑Breathing Problem	❑Fainting spells/ Dizziness	❑High blood pressure	❑Renal Dialysis	❑Ulcers
❑Bruise Easily	❑Frequent Cough	❑Hives or rash	❑Rheumatic Fever	❑Venereal Disease
❑Cancer	❑Frequent Diarrhea	❑Hypoglycemia	❑Rheumatism	❑Yellow Jaundice
❑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:_____

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: _____

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: _____

SCH
Shenandoah
Community Health

Consents

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

Patients who are unable to keep a scheduled appointment must cancel prior to 24 hours of the appointment. Appointments cancelled less than 24 hours in advance, or not all, may subject the patient to scheduling restrictions after the third occurrence. *Does not apply to behavioral health*.

I acknowledge that I am aware SCH's "*Notice of Privacy Practices*" for protected health information is available in the waiting area of each department or on the website at shencommhealth.com. A printed copy is available by request.

I authorize staff of SCH to take my picture or scan my photo ID and place it in my Electronic Medical Record for purposes of identification. In addition, I also give consent to SCH to take photographs of rashes, endoscopy, colonoscopy, and other medical images for the purpose of medical documentation. I understand that photographs will be protected as part of my medical record and unless otherwise required by federal or state law as noted in the SCH "*Notice of Privacy Practices,*" will not be released without my 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
Signature	Date
Parent or Legal Guardian Signature (if patient is a minor)	Date
Witness	Date

SCH Shenandoah Community Health

Authorization to Release or Obtain Confidential Information

(Autorización para divulgar u obtener información confidencial)

☐ **Primary Care** ☐ **Behavioral Health** ☐ **Women's Health** ☐ **Healthy Smiles Dental**

Patient Name (*Nombre del Paciente*):	
Date of Birth (*Fecha de Nacimiento*)	Social Security No. (*Número de Seguro Social)*

The purpose for release of information:

(*El objetivo de la divulgación de la información mencionada anteriormente es)*:

☐ Transfer of Care (*Transferencia de Cuidados)* ☐ Continuatation of Care (*Continuar el cuidado medico)* ☐ Legal *(Legal)* ☐ Other *(Otros)*_____

I hereby authorize (*Por la presente autorizo a):*

Name (*Nombre*)	
Address (*Dirección*)	
Telephone (*Teléfono*)	Fax

☐ Release or Request Confidential Information *(Divulgar u solicitar información confidencial)* ☐ Discuss Confidential Information *(divulgar información confidencial)*

Name (*Nombre*)	
Address (*Dirección*)	
Telephone (*Teléfono*)	Fax

The following medical records: *(Los siguientes expedients medicos)*

☐ Medication List (*Lista de medicamentos*) ☐ Progress Notes (*Notas de progreso)* ☐ Lab Results (*Resultados de análisis*) ☐ Psychological Evaluation *(Evaluación psicológica)* ☐ Diagnosis List *(Lista de diagnósticos)*

☐ Intake Assessment *(Evaluación Inicial)* ☐ Diagnostic Reports (*Reporte del diagnóstico)* ☐ Immunizations (*Registro de vacunas*) ☐ Appointment List *(Lista de citas)* ☐ Psychiatric Evaluation *(Evaluación Psiquiátrica)*

Other (*Otros*)_____

Dates of Service: (*de las fechas de servicio)*_____

INITIALS ARE REQUIRED FOR RELEASE OF THE FOLLOWING INFORMATION

Sus iniciales son requeridas para divulgar la siguiente información

	Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) (*Síndrome de Inmunodeficiencia Adquirido [SIDA] o infecciones con el Virus de Inmunodeficiencia Humano*)
	Behavioral/Mental Health/Psychotherapy Records (*Expediantes Conductuales/Salud Mental/Psicoterapia)*
	Treatment for Substance /Alcohol Abuse (*Tratamiento de abuso de alcohol o de sustancias)*
	Child Abuse and/or Domestic Abuse history (*Historial de maltrato infantil y/o violencia doméstica*)
	Treatment of STD (Tratamiento de Enfermedades de Transmisión Sexual)

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated, and signed communication to Shenandoah Valley Medical System, Inc. which does business as Shenandoah Community Health. This consent will expire in one year from the date signed, unless otherwise stated as follows:
(Entiendo que este consentimiento es voluntario y que lo puedo revocar en cualquier momento [excepto a tal punto en que la acción en la cual se basa este consentimiento ya se haya efectuado] por medio de un comunicado escrito, fechado y firmado, dirigido a Shenandoah Valley Medical System, Inc., *la cual opera como* Shenandoah Community Health. *Esta autorización se vence en un año a partir de la fecha de firma, a no ser que se indique lo contrario, de acuerdo a lo siguiente:*)

- I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed and my treatment will not be affected by my refusal to sign this authorization.
  (Entiendo que puedo rehusarme a firmar esta autorización. Si lo hago, el historial médico identificado no será divulgado y mi tratamiento no será afectado por mi denegación a firmar esta autorización.)

- I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.
  (Entiendo que mis registros de uso de sustancias están protegidos por la ley federal, incluidas las regulaciones federales que rigen la confidencialidad de los registros de pacientes con trastornos por uso de sustancias, 42 C.F.R. Parte 2, y la Ley de Portabilidad y Responsabilidad del Seguro Médico de 1996 ("HIPAA"), 45 C.F.R. Partes 160 y 164, y no se puede divulgar sin mi consentimiento por escrito a menos que las regulaciones dispongan lo contrario.)

- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the Health Insurance Portability and Accountability Act (HIPAA).
  (La información utilizada o divulgada conforme a esta autorización puede estar sujeta a una subsiguiente divulgación por parte del receptor y ya no estar protegida por la Ley de Portabilidad y Responsabilidad de Seguros de Salud [HIPPA, por las siglas en inglés de Health Insurance Portability and Accountability Act].

- I am entitled to a copy of this authorization.
  (Tengo derecho a recibir una copia de esta autorización.)

_____ _____

Signature of Patient parent, guardian, or legal representative
(Firma del paciente, padre, tutor legal o representante legal)

Date *(Fecha de firma)*

_____

Signature of Provider if Required.