



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) 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	
GENDER IDENTITY <input type="checkbox"/> Male <input type="checkbox"/> Transgender Male/Female-to-Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female/Male-to-Female <input type="checkbox"/> Other <input type="checkbox"/> Choose not to disclose			SEXUAL ORIENTATION <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Don't Know <input type="checkbox"/> Straight (not lesbian or gay) <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Bisexual <input type="checkbox"/> 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) Single Married Widowed Divorced Legally Separated		PRIMARY LANGUAGE (Circle One) English Spanish American Sign Language Creole Haitian Creole Other: _____		
EMERGENCY CONTACT		NAME	TELEPHONE	RELATIONSHIP
PREFERRED PHARMACY			PRIMARY CARE PROVIDER	
HOUSING STATUS <input type="checkbox"/> Not Homeless <input type="checkbox"/> Doubling Up <input type="checkbox"/> Transitional <input type="checkbox"/> Shelter <input type="checkbox"/> Street		RACE <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other: _____		
MIGRANT WORKER STATUS <input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal		ETHNICITY <input type="checkbox"/> Not Hispanic Or Latino <input type="checkbox"/> Hispanic Or Latino		
LANGAUGE BARRIER (Circle One) YES NO		ARE YOU A MILITARY SERVICE VETERAN? (Circle One) YES NO		
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

SIGN _____ DATE _____



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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 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 area 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.

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 have received Shenandoah Community Health's "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 "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

Signature

Date

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

Date

Witness

Date



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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: _____



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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 (<i>Nombre del Paciente</i>):	
Date of Birth (<i>Fecha de Nacimiento</i>)	Social Security No. (<i>Número de Seguro Social</i>)

The purpose for release of information:

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

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

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

Name (<i>Nombre</i>)	
Address (<i>Dirección</i>)	
Telephone (<i>Teléfono</i>)	Fax

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

Name (<i>Nombre</i>)	
Address (<i>Dirección</i>)	
Telephone (<i>Teléfono</i>)	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) (<i>Síndrome de Inmunodeficiencia Adquirido [SIDA] o infecciones con el Virus de Inmunodeficiencia Humano</i>)
	Behavioral/Mental Health/Psychotherapy Records (<i>Expedientes Conductuales/Salud Mental/Psicoterapia</i>)
	Treatment for Substance /Alcohol Abuse (<i>Tratamiento de abuso de alcohol o de sustancias</i>)
	Child Abuse and/or Domestic Abuse history (<i>Historial de maltrato infantil y/o violencia doméstica</i>)
	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 [HIPAA, 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.



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