



PATIENT INFORMATION

PATIENT INFORMATION			
LAST NAME	FIRST NAME	MIDDLE NAME / INITIAL	PREVIOUS NAME / PREFERRED NAME
SOCIAL SECURITY #	BIRTHDATE (MM/DD/YYYY)	EMAIL ADDRESS	
<p><i>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.</i></p>			
BIRTH SEX (Circle One)	CURRENT GENDER (Circle One)	PREFERRED PRONOUN (Circle One)	
Male Female Undifferentiated Unknown	Male Female Undifferentiated	He, Him, His She, Her, Hers They, Them, Theirs Other Ze, Hir (Gender Free) Asked but unknown Decline to Answer	
GENDER IDENTITY		SEXUAL ORIENTATION	
<input type="checkbox"/> Male <input type="checkbox"/> Transgender Male/Female-to-Male <input type="checkbox"/> Other <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female/Male-to-Female <input type="checkbox"/> Non-binary <input type="checkbox"/> Choose not to disclose		<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 _____	
BILLING ADDRESS		CITY, STATE, ZIP	PHONE NUMBER
SECONDARY ADDRESS		CITY, STATE, ZIP	PREFERRED CONTACT METHOD
MARITAL STATUS (Circle One)	PRIMARY LANGUAGE (Circle One)		
Single Married Widowed Divorced Legally Separated	English Spanish American Sign Language Creole Haitian Creole Other: _____		
EMERGENCY CONTACT	NAME	TELEPHONE	RELATIONSHIP
PREFERRED PHARMACY		PRIMARY CARE PROVIDER	
HOUSING STATUS		RACE	
<input type="checkbox"/> Not Homeless <input type="checkbox"/> Doubling Up <input type="checkbox"/> Transitional <input type="checkbox"/> Shelter <input type="checkbox"/> Street		<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Black/African American <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Asian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Samoan <input type="checkbox"/> Vietnamese <input type="checkbox"/> White <input type="checkbox"/> More than one race	
MIGRANT WORKER STATUS		ETHNICITY	
<input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal		<input type="checkbox"/> Chicano <input type="checkbox"/> Cuban <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Non-Hispanic Or Latino <input type="checkbox"/> Peurto Rican <input type="checkbox"/> Spanish <input type="checkbox"/> Unknown	
LANGAUGE BARRIER (Circle One)		ARE YOU A MILITARY SERVICE VETERAN? (Circle One)	
YES NO		YES NO	
CHIEF COMPLAINT/REASON FOR VISIT			
REFERRAL SOURCE			

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.

HOUSEHOLD SIZE AND ANNUAL FAMILY INCOME

FAMILY SIZE: _____

ANNUAL FAMILY INCOME: \$ _____

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



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.



Pre-medical Screening

Date completed: _____

Name: _____ Date of Birth: _____

Reason for being seen: _____

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.

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

Medication	Dose	How Often?	Who Prescribed?

2. Are you currently taking a blood thinner?

3. 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: _____

4. List all allergies, including allergies to medication:

5. Do you smoke? Yes No

If yes, how much? _____ How long? _____

6. Do you drink alcoholic beverages? Yes No

If yes, how much? _____

7. Do you use marijuana or other drugs? Yes No

If yes, which drug(s)? _____

8. Are you under a physician's care now? Yes No If yes, please explain:

9. Have you ever been hospitalized or had a major operation? Yes No If yes, please explain:

10. Have you ever had a serious head or neck injury? Yes No If yes, please explain:

11. 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"/> Osteoporosis | <input type="checkbox"/> Swelling of limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pain in jaw joints | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Aspersers disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Parathyroid disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Radiation Treatments | <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"/> Recent Weight Loss | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or rash | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Chemotherapy | | | <input type="checkbox"/> Rheumatism | |

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: _____



Appointment Agreement

Late Arrival/Non-confirmed/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. Patients who are unable to keep a scheduled appointment must cancel by 1:00pm the day prior to the appointment. Additionally, all patients must confirm appointments by 1:00pm the day prior to the appointment. Appointments cancelled after 1:00pm the day prior, or not at all, may subject the patient to scheduling restrictions after the third occurrence.

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. To allow another adult to bring your child to the appointment they must be listed on the consent form. If the adult accompanying your 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. **Minors must be accompanied by a parent or legal appointment at the first appointment.**

Accompanying Children to Exam Rooms

In order to continue allowing parents/guardians to accompany their children to our child-friendly operatories during their dental visit, we ask the parent/guardian to follow these procedures:

- Only **ONE** adult is to accompany a child to the clinical area.
- All siblings of patients must remain in the waiting area with an 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.
- 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 a child to the operatory until treatment begins. Once treatment begins, we will ask that all parents/guardians remain in the waiting area.

Sibling Appointments

- We no longer schedule 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: _____





Healthy Smiles

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 by 1:00pm the day prior to the appointment. Additionally, all patients must confirm appointments by 1:00pm the day prior to the appointment. Appointments cancelled after 1:00pm the day prior, or not at all, may subject the patient to scheduling restrictions after the third occurrence.

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 authorize 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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