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)
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
☐ Male ☐ Transgender Male/Female-to-Male ☐ Other
☐ Female ☐ Transgender Female/Male-to-Female
☐ Non-binary ☐ Choose not to disclose

SEXUAL ORIENTATION
☐ Lesbian or Gay ☐ Don't Know
☐ Straight (not lesbian or gay) ☐ 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)
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
☐ Not Homeless ☐ Doubling Up
☐ Transitional ☐ Shelter
☐ Street

RACE
☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian
☐ Other Pacific Islander ☐ White ☐ Other: _____________________________________

MIGRANT WORKER STATUS
☐ Migrant ☐ Seasonal

ETHNICITY
☐ Not Hispanic Or Latino ☐ Hispanic Or Latino

LANGAUGE BARRIER (Circle One)
YES NO

ARE YOU A MILITARY SERVICE VETERAN? (Circle One)
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

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.

SCH Shenandoah Community Health

SHENANDOAH COMMUNITY HEALTH

Women's Health Information

Name: ____ Date of Birth:__________________

What type of work do you do?____

When was your last immunization for:
Tetanus______/______/______ Pneumonia______/______/______ Influenza (Flu) ______/______/______

Have you ever been sexually active? Yes / No
Are you currently sexually active? Yes / No
Age first pregnancy:__________
Current birth control method:____________________
Any problems? ______________________________
Date of your last mammogram _____/_____/_____

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 _____/_____/____

PREGNANCY HISTORY

Please include miscarriage/abortions	1st pregnancy	2nd pregnancy	3rd pregnancy	4th pregnancy	5th pregnancy	6th pregnancy
Month/Year Delivered						
Weeks gestation (40 is due date)						
Male or Female						
Baby's weight						
Vaginal or cesarean delivery						
Where (town or hospital name)						
Complications						

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:
____
____
____

Over →

Name: ____ Date of Birth:______________________

Are you allergic to any medications, anesthetics, iodine, latex, tape, or foods, anything else?   Yes / No

____

____

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______________________________ High Blood Pressure__________________________

Cancer_____________________________________ Mental Health Issues__________________________

Diabetes___________________________________ Stroke_______________________________________

Drug/Alcohol Addiction_______________________ Thyroid Issue__________________________________

Heart Issues_________________________________

Other:____

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 (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

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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.

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