



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.

Name: _____ Date of Birth: _____

What type of work do you do? _____

When was your last immunization for:

Tetanus _____ / _____ / _____ Pneumonia _____ / _____ / _____ Influenza (Flu) _____ / _____ / _____

Women:

Have you ever been sexually active? Yes / No

Are you currently sexually active? Yes / No

Number of pregnancies: _____

Age first pregnancy: _____

Number of full term births: _____

Number of preterm births: _____

Number of abortions: _____

Number of miscarriages: _____

Number of ectopic pregnancies: _____

Number of living children: _____

Date of your last mammogram _____ / _____ / _____

Number of Cesarean sections: _____

Number of vaginal deliveries: _____

Complications: _____

Current birth control method _____

If Birth Control Pill, name the type: _____

Any problems? _____

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 _____ / _____ / _____

Men:

Have you ever been sexually active? Yes / No

Are you currently sexually active? Yes / No

Do you check your testicles monthly? Yes / No

Date of your last colonoscopy _____ / _____ / _____

Children:

Any problems during mother's pregnancy? _____ Birth weight? _____

Any problems during labor/delivery? _____

**Please bring a copy of the child's immunization record*

All:

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: _____

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

Name: _____ Date of Birth: _____

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	Hearing difficulty
Back Trouble	HIV
Ulcers	Bowel Trouble
Trouble swallowing	Diarrhea
Arthritis	Infertility
Anemia	Constipation
Heart Trouble (Chest Pain, Irregular Heartbeat)	Urinary Problems (Infection, Loss of Bladder Control)
Hepatitis	Breast Problems
Stroke	Cancer
High Blood Pressure	Thyroid Problems
Broken Bones	Sexual Problems
Asthma	Back Trouble
Emphysema	Seizures
Diabetes	Mental Health Issues (Depression, Anxiety, Stress)
Pneumonia	Vision problems (Blurry Vision, Glaucoma, Cataracts)
Tuberculosis	Other: _____
Drug or Alcohol Addiction	_____
Heartburn	_____

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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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) (Síndrome de Inmunodeficiencia Adquirido [SIDA] o infecciones con el Virus de Inmunodeficiencia Humano)
	Behavioral/Mental Health/Psychotherapy Records (Expedientes 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 [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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