

**PATIENT INFORMATION**

LAST NAME	FIRST NAME	MIDDLE NAME / INITIAL	PREVIOUS NAME / NICKNAMES(S)
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SOCIAL SECURITY #	BIRTHDATE (MM/DD/YYYY)	EMAIL ADDRESS
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\*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
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GENDER IDENTITY <input type="checkbox"/> Male <input type="checkbox"/> Male-to-Female (MTF)/Transgender Female/Trans Woman <input type="checkbox"/> Female <input type="checkbox"/> Female-to-Male (FTM)/Transgender Male/Trans Man <input type="checkbox"/> Genderqueer, neither exclusively male nor female <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Additional gender category or other, please specify _____	SEXUAL ORIENTATION <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Don't Know <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Lesbian, gay, homosexual <input type="checkbox"/> Something else, please describe _____
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ADDRESS	CITY, STATE, ZIP	PHONE NUMBER
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BILLING ADDRESS (If Different Than Above)	CITY, STATE, ZIP	PREFERRED CONTACT METHOD
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MARITAL STATUS (Circle One) Single    Married    Widowed Divorced    Legally Separated	PRIMARY LANGUAGE (Circle One) English    Spanish    American Sign Language    Creole    Haitian Creole Other: _____
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EMERGENCY CONTACT	NAME	TELEPHONE	RELATIONSHIP
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PREFERRED PHARMACY	PRIMARY CARE PROVIDER
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**RESPONSIBLE PARTY INFORMATION (If Different Than Patient)**

NAME (Last, First, Middle)	SSN#	BIRTHDATE
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ADDRESS	CITY, STATE, ZIP	TELEPHONE
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RELATIONSHIP TO PATIENT

HOUSING STATUS <input type="checkbox"/> Doubling Up <input type="checkbox"/> Not Homeless <input type="checkbox"/> Shelter <input type="checkbox"/> Street <input type="checkbox"/> Transitional	RACE <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> More Than One Race <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other: _____
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MIGRANT WORKER STATUS <input type="checkbox"/> Migrant <input type="checkbox"/> Not A Farmworker <input type="checkbox"/> Seasonal	ETHNICITY <input type="checkbox"/> Not Hispanic Or Latino <input type="checkbox"/> Hispanic Or Latino <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican <input type="checkbox"/> Dominican <input type="checkbox"/> Guatemalan <input type="checkbox"/> Haitian <input type="checkbox"/> Honduran <input type="checkbox"/> Jamaican <input type="checkbox"/> Venezuelan <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Latin American <input type="checkbox"/> Mexican American <input type="checkbox"/> Other: _____
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LANGAUGE BARRIER (Circle One) YES                      NO	ARE YOU A MILITARY SERVICE VETERAN? (Circle One) YES                      NO
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**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

**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.**

**BASED UPON YOUR FAMILY SIZE AND ANNUAL FAMILY INCOME, WHICH COLUMN FROM THE CHART BELOW WOULD BEST FIT YOUR FINANCIAL SITUATION?**

*Example: family size of 3 with annual family income of \$25,000, circle column letter B*

**CIRCLE ONLY THE LETTER OF THE COLUMN : A B C D**

FAMILY SIZE	ANNUAL FAMILY INCOME			
	A	B	C	D
1	\$12,140 or less	\$12,141 - \$18,210	\$18,211 - \$24,280	More than \$24,281
2	\$16,460 or less	\$16,461 - \$24,690	\$24,691 - \$32,920	More than \$32,921
3	\$20,780 or less	\$20,781 - \$31,170	\$31,171 - \$41,560	More than \$41,561
4	\$25,100 or less	\$25,101 - \$37,650	\$37,651 - \$50,200	More than \$50,201
5	\$29,420 or less	\$29,421 - \$44,130	\$43,131 - \$58,840	More than \$58,841
6	\$33,740 or less	\$33,741 - \$50,610	\$50,611 - \$67,480	More than \$67,481
7	\$38,060 or less	\$38,061 - \$57,090	\$57,091 - \$76,120	More than \$76,121
8	\$42,380 or less	\$42,381 - \$63,570	\$63,571 - \$84,760	More than \$84,761

**SIGN** \_\_\_\_\_ **DATE** \_\_\_\_\_



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

First day of Last Menstrual Period \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Are you currently sexually active? Yes / No

Date of your last Pap Test \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Age first pregnancy: \_\_\_\_\_

Normal? Yes / No

Current birth control method: \_\_\_\_\_

Have you had a hysterectomy? Yes / No

Any problems? \_\_\_\_\_

Are you Pre/Post Menopausal? Yes / No

Date of your last mammogram \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Date of your last colonoscopy \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**PREGNANCY HISTORY**

<i>Please include miscarriage/abortions</i>	<u>1st pregnancy</u>	<u>2nd pregnancy</u>	<u>3rd pregnancy</u>	<u>4th pregnancy</u>	<u>5th pregnancy</u>	<u>6th pregnancy</u>
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:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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



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

I understand that I am responsible for contacting the office at least 48 hours in advance if I am unable to keep my scheduled appointment.

I acknowledge that I have received Shenandoah Community Health's "Joint 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 "Joint 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

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



## Authorization to Discuss

I authorize Shenandoah Community Health Center to discuss my health information with the following:

1.) Name \_\_\_\_\_  
Phone \_\_\_\_\_  
Relationship \_\_\_\_\_

2.) Name \_\_\_\_\_  
Phone \_\_\_\_\_  
Relationship \_\_\_\_\_

This **does not include** information regarding substance abuse treatment, HIV or mental health treatment unless specifically granted below by **initialing** next to each item to be discussed.

\_\_\_\_\_ Substance Abuse Treatment

\_\_\_\_\_ HIV Treatment

\_\_\_\_\_ Mental Health Treatment

\_\_\_\_\_ Child Abuse and/or Domestic Abuse history

\_\_\_\_\_ STD Treatment

This authorization is valid for one year from the date signed unless revoked by me in writing. I am not required to sign this authorization. It is my responsibility to notify Shenandoah Community Health Center of any changes to contacts or phone numbers. Shenandoah Community Health Center does not condition treatment, payment, or benefit eligibility on signing of this form.

**Patient Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

**Phone #** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Relationship / Legal Authorization if not Patient** \_\_\_\_\_

**Date** \_\_\_\_\_

