



PATIENT INFORMATION

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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) 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"/> 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		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 _____	
BILLING ADDRESS		CITY, STATE, ZIP	PHONE NUMBER
SECONDARY ADDRESS		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	
CHIEF COMPLAINT/REASON FOR VISIT			
REFERRAL SOURCE			

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 the day prior to the appointment. Appointments cancelled the day of, 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 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



Medical Consent Form

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: _____

