SCH
Shenandoah
Community Health®

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)	CURRENT GENDER (Circle One)	PREFERRED PRONOUN (Circle One)
Male Female	Male Female	He, Him, His She, Her, Hers They, Them, Theirs Other
Undifferentiated Unknown	Undifferentiated	Ze, Hir (Gender Free) Asked but unknown Decline to Answer

GENDER IDENTITY	SEXUAL ORIENTATION
☐ Male ☐ Transgender Male/Female-to-Male ☐ Other	☐ Lesbian or Gay ☐ Don't Know
☐ Female ☐ Transgender Female/Male-to-Female	☐ Straight (not lesbian or gay) ☐ Choose not to disclose
☐ Non-binary ☐ 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)	PRIMARY LANGUAGE (Circle One)
Single Married Widowed	English Spanish American Sign Language Creole Haitian Creole
Divorced Legally Separated	Other:_____

EMERGENCY CONTACT NAME	TELEPHONE	RELATIONSHIP

PREFERRED PHARMACY	PRIMARY CARE PROVIDER

HOUSING STATUS	RACE
☐ Not Homeless ☐ Doubling Up	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian
☐ Transitional ☐ Shelter	☐ Other Pacific Islander ☐ White ☐ Other: _____
☐ Street	

MIGRANT WORKER STATUS	ETHNICITY
☐ Migrant ☐ Seasonal	☐ Not Hispanic Or Latino ☐ Hispanic Or Latino

LANGAUGE BARRIER (Circle One)	ARE YOU A MILITARY SERVICE VETERAN? (Circle One)
YES NO	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

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Health Information

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
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_____
Cancer_____
Diabetes_____
Drug/Alcohol Addiction_____
Heart Issues_____
Other:_____
High Blood Pressure_____
Mental Health Issues_____
Stroke_____
Thyroid Issue_____

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

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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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: _____