PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME / INITIAL	PREVIOUS NAME / NICKNAMES(S)

SOCIAL SECURITY #	BIRTHDATE (MM/DD/YYYY)	EMAIL ADDRESS	BIRTH SEX (Circle One) Male Female

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 Divorced Legally Separated	English Spanish American Sign Language Creole Haitian Creole Other:____

EMERGENCY CONTACT	NAME	TELEPHONE	RELATIONSHIP

PREFERRED PHARMACY	PRIMARY CARE PROVIDER

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

HOUSEHOLD SIZE AND ANNUAL INCOME

NUMBER LIVING IN HOUSEHOLD: ______________________________	**HOUSEHOLD INCOME: $** ______________________

Over

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

SIGN ____ **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.

Healthy Smiles

Pre-medical Screening

Date completed: ______________________

Name: ______________________________________ Date of Birth:________________________________
Reason for being seen:____

Primary Care Physician Name and Phone Number:____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

1. List all medications you are currently taking and the name of the doctor prescribing:

Medication	Dose	How Often?	Who Prescribed?

2. Are you currently taking a blood thinner?

3. Check over-the-counter medications taken:
   - ☐ Aspirin ☐ Antacids ☐ Allergy Relief Medicine ☐ Herbal Remedies/ Supplements
   - ☐ Tylenol ☐ Laxatives ☐ Sleep Medicine ☐ Weight Loss Aids
   - ☐ Excedrin ☐ Sinus Relief Medicine ☐ Muscle/ Weight gain aids
   - ☐ Other:______________________________________

4. List all allergies, including allergies to medication:

   ____
   ____
   ____
   ____

5. Do you smoke? ❑Yes ❑No
   If yes, how much? ______________________________ How long? ____________________________

6. Do you drink alcoholic beverages? ❑Yes ❑No
   If yes, how much? ______________________________________

7. Do you use marijuana or other drugs? ❑Yes ❑No
   If yes, which drug(s)? ___________________________________

8. Are you under a physician's care now? ❑Yes ❑No If yes, please explain:
____

9. Have you ever been hospitalized or had a major operation? ❑Yes ❑No If yes, please explain:
____

10. Have you ever had a serious head or neck injury? ❑Yes❑No If yes, please explain:
____

11. Are you on a special diet?❑Yes ❑No

Women, are you: ❑Pregnant ❑ Trying to get pregnant ❑Nursing ❑Taking oral contraceptives

All Patients: do you have, or have you had, any of the following:

❑AIDS/HIV Positive
❑Alzheimer's disease
❑Anaphylaxis
❑Anemia
❑Angina
❑Arthritis/ Gout
❑Artificial Heart Valve
❑Artificial Joint
❑Asthma
❑Autism
❑Blood Transfusion
❑Breathing Problem
❑Bruise Easily
❑Cancer
❑Chemotherapy
❑Chest pains
❑Cold Sores/ Fever Blisters
❑Congenital Heart disease
❑Convulsions
❑Cortisone Medicine
❑Diabetes
❑Drug Addiction
❑Easily Winded
❑Emphysema
❑Epilepsy or Seizures
❑Excessive thirst
❑Fainting spells/ Dizziness
❑Frequent Cough
❑Frequent Diarrhea
❑Frequent Headaches
❑Genital Herpes
❑Glaucoma
❑Hay Fever
❑Heart Attack/ Failure
❑Heart Murmur
❑Heart Pace Maker
❑Heart trouble/ Disease
❑Hemophilia
❑Hepatitis A
❑Herpes
❑High blood pressure
❑Hives or rash
❑Hypoglycemia
❑Irregular Heartbeat
❑Kidney Problems
❑Leukemia
❑Liver Disease
❑Low Blood Pressure
❑Lung Disease
❑Mitral Valve Prolapse
❑Osteoporosis
❑Pain in jaw joints
❑Parathyroid disease
❑Radiation Treatments
❑Recent Weight Loss
❑Renal Dialysis
❑Rheumatic Fever
❑Rheumatism
❑Scarlet Fever
❑Shingles
❑Sickle Cell Disease
❑Sinus Trouble
❑Spina Bifida
❑Stomach/ Intestinal Disease
❑Stroke
❑Swelling of limbs
❑Thyroid Disease
❑Tuberculosis
❑Tumors or Growths
❑Ulcers
❑Venereal Disease
❑Yellow Jaundice

Have you ever had any serious illness not listed above? ❑Yes ❑No If yes, please explain:___________
____

Comments:____
____

Emergency Contact Name: ________________________ Phone: ________________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or Patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent or legal guardian: ________________________

Date: __________________

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SCH Shenandoah Community Health | Healthy Smiles

Appointment Agreement

Late Arrival/Non-confirmed/No Show

We do our very best to stay on schedule. We also understand that from time to time an emergency will arise and you may be late or miss an appointment. We reserve the right to reschedule patients if they are not on time for their appointment. Please call if you are running late. Patients who are unable to keep a scheduled appointment must cancel by 1:00pm the day prior to the appointment. Additionally, all patients must confirm appointments by 1:00pm the day prior to the appointment. Appointments cancelled after 1:00pm the day prior, or not at all, may subject the patient to scheduling restrictions after the third occurrence.

Parent/Legal Guardian

All children must be accompanied by a parent or legal guardian (with court papers) for each visit and remain present during the entire appointment. To allow another adult to bring your child to the appointment they must be listed on the consent form. If the adult accompanying you child is not on the consent form, they must provide a note with the following information: name and birth date of the child, name of adult accompanying the child, any current medical conditions or medications, consent for treatment being provided that day and the signature and phone number of the parent and today's date. **Minors must be accompanied by a parent or legal appointment at the first appointment.**

Accompanying Children to Exam Rooms

In order to continue allowing parents/guardians to accompany their children to our child-friendly operatories during their dental visit, we ask the parent/guardian to follow these procedures:

- Only **ONE** adult is to accompany a child to the clinical area.
- All siblings of patients must remain in the waiting area with an accompanying adult. Children under the age of 11 are unable to remain in waiting area without adult supervision.
- For the protection of your child and our staff, we are unable to watch your children during scheduled appointments.
- If the patient should become uncooperative at any time during treatment, and the provider feels it would be in the best interest of the patient, it may be necessary to ask the parent to be seated in the waiting area for the remainder of the appointment.
- Restorative appointments- only one parent is allowed to accompany a child to the operatory until treatment begins. Once treatment begins, we will ask that all parents/guardians remain in the waiting area.

Sibling Appointments

- We no longer schedule more than two siblings together in one day.
- If we are scheduling more than one sibling, they must be able to be alone in the exam room.
- If you wish to accompany your child to the exam room, you must have a second adult over the age of 18 to remain in the waiting room with the sibling while you are in the exam room.

____ _____________

Patient or Parent/ Guardian signature Date

Print Patient Name: ____

HEALTHY SMILES COMMUNITY ORAL HEALTH CENTER

OF SHENANDOAH COMMUNITY HEALTH

Medical Consent Form for Minor

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: ____

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 by 1:00pm the day prior to the appointment. Additionally, all patients must confirm appointments by 1:00pm the day prior to the appointment. Appointments cancelled after 1:00pm the day prior, or not at all, may subject the patient to scheduling restrictions after the third occurrence.

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