Shenandoah Community Health

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)

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

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 COMMUNITY HEALTH

Women's Health Information

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
Are you currently sexually active? Yes / No
Age first pregnancy:_____
Current birth control method:_____
Any problems? _____
Date of your last mammogram _____/_____/_____

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 _____/_____/____

PREGNANCY HISTORY

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

_____

_____

_____

Over

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
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_____ 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? _____

SCH
Shenandoah
Community Health

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