Patient Name: Patient ID: Date of Birth: __ __/__ __/__ __ __ __

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Social Security Number
			__ __ __ - __ __ - __ __ __ __

Date of Birth	Sex Assigned at Birth	Transgender?	Marital Status
__ __/__ __/__ __ __ __	☐ Female ☐ Male	☐ Yes	☐ Single ☐ Married ☐ Divorced ☐ Widowed

Mailing Address	City	State	Zip

Physical Address (if different than mailing address)	City	State	Zip

Home Phone	Cell Phone	Work Phone

Employer Name	Employer Address		
	City	State	Zip

Employment Status	Student?	College or technical school?
☐ Full time ☐ Part time ☐ Unemployed ☐ Retired ☐ Self Employed ☐ Disabled	Grade: _____	☐ Full time ☐ Part time

RESPONSIBLE PARTY (person to be billed if other than patient)

Last Name	First Name	Date of Birth
		__ __/__ __/__ __ __ __

Mailing Address (if different than patient)	City	State	Zip

Primary Phone	Relationship to Patient

Does Patient Have Insurance? Insurance Company:	Member Number:	Group Number:

The following information can help us to obtain grants and funding. THANK YOU in advance for completing this.

Race
☐ White (including Latino/Hispanic) ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Hawaiian/Pacific Islander

Ethnicity	Primary Language:	Will you need an interpreter?
☐ Hispanic/Latino ☐ Not Hispanic/Latino		

Housing Situation
☐ Own or rent ☐ Staying with friends/sharing home ☐ Public Housing ☐ Homeless Shelter ☐ Transitional ☐ Living on street

How many dependents live in your house that you could claim on taxes? _____# adults (include you) _____# children	Household Income (all forms of income and support) Monthly _____	Are you a veteran of US Armed Forces? ☐ Yes ☐ No

FOR OFFICE USE ONLY

Qualify For Sliding Fee Discount Program?
☐ 138% & below ☐ 139-200% ☐ 201-250% ☐ 251-300% ☐ 301%+ ☐ Unknown/ Hasn't reported income

Intake completed by: Date: Data entered by: Date:

Patient Name: Date of Birth:

CONSENT TO SERVICES AND CARE

Consent for Treatment:

I will allow Shenandoah Community Health Clinic (Clinic) to treat the patient. I will provide, when asked, any and all information for any illness or injury, medical history, prescriptions or treatment, and copies of all medical records. I understand that the Clinic provides services without regard to race, creed, color, or national origin.

Financial Agreement:

I authorize direct payment to the Clinic for any health care received. I will allow the Clinic to file claims on my behalf. I understand that I am responsible for services not paid by my insurance plan and that I may apply for discounted services where fees are based on my family's income and subsidized by grants and donations. I understand that I may incur fees for services from outside entities like hospitals and specialty practices and that charitable assistance programs may be available to make these services more affordable.

Notice of Deemed Consent for Infections Disease Testing:

By my signature, I understand that I have been informed of Virginia state code 32.1-45.1 regarding blood testing. In the event that a health care provider or employee is exposed to the patient's bodily fluids in a manner which may transmit disease, the patient will be deemed to have consented to testing for HIV and Hepatitis and to the disclosure of the test results to that health care employee.

I agree that this permission will be valid until taken away in writing or replaced by one at a later date. A photocopy of the agreement will be considered effective and as valid as the original.

Patient/Guardian Signature:_____ Date: __ __/ __ __/ __ __ __ __

Print Name:_____ Relationship to Patient: _____

CONTACT INFORMATION

Tell us the best phone number to reach you during the day: _____

Tell us the best phone number to leave messages or appointment reminders: _____

Can the Clinic leave extended messages on the message phone number above? ☐ Yes ☐ No

Please list all individuals with whom we may discuss your medical care (HIPPA). THESE INDIVIDUALS WILL ALSO BE YOUR EMERGENCY CONTACTS. We will not discuss your health care with anyone NOT listed below.

NAME (First and Last)	Primary Phone	Relationship to Patient

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Entered By: Scanned By: Date:

Patient Name: Date of Birth:

The best health care is a partnership between the patient, their family and the healthcare provider. Please review the information below and initial each item then sign below.	
CHECK-IN: I will have my insurance card and/or my eligibility documents available when I check in and upon request for follow up visits.	
ARRIVAL TIME: I will arrive 30 minutes early as a new patient, or to obtain a new service (medical, counseling, dental). I will arrive 15 minutes early as an established patient.	
CURRENT MEDICATIONS: I understand that providers can help me best when I bring all my medications, prescription bottles, herbals and supplements to my appointments and thus I am required to bring them each time I see a medical provider.	
PRESCRIPTION REFILLS & MEDICATION ASSISTANCE: I understand that providers are not always available and medicines that are shipped may take weeks. For medications through local pharmacies, I will call the pharmacy several days in advance of running out. For medications I obtain through the Clinic, I will call when I open my last bottle.	
CONTROLLED SUBSTANCES: Shenandoah Community Health Clinic manages pain and other conditions with non-opiate and non-controlled substances. I understand that the Clinic will assist me by providing alternatives.	
MEDICAL RECORDS: The Clinic participates with the prescription monitoring program. I give permission to the Clinic to obtain or share my medical records with any hospital, practice or pharmacy where I have received services and between the medical and dental programs at this Clinic. I understand that a consent form is required to transfer health records from a previous provider.	
PRIVACY PRACTICE: I have read and understand the Clinic's Notice of Privacy Practice.	
CANCELLATION OF APPOINTMENT: I understand that part of taking charge of my health is keeping up with health appointments. I understand that I should give at least 24 hours' notice if I am unable to come to an appointment so that other patients may be helped. I understand that I may be charged a $10 reinstatement fee -- plus the cost of the missed appointment and advance payment of my next appointment -- if I miss an appointment without any advance notice.	

Patient/Guardian Signature: _____ Date: __ __ / __ __ / __ __ __ __

Print Name: _____ Relationship to Patient: _____

This person helped me with this paperwork: Print Name: _____

Signature _____ Date: __ __ / __ __ / __ __ __ __

OFFICE USE ONLY

Scanned By: **Date:**

HEALTH HISTORY

NAME / *NOMBRE:* _____ **DATE OF BIRTH** / *FECHA NACIMIENTO:* _____

PHONE / *TELEPHONO:* _____

EMERGENCY CONTACT / *CASO DE EMERGENCIA, CONTACTAR:* _____ **PHONE** / *TELEPHONO:* _____

FORMER PHYSICIAN / *ALGUN MEDICO QUE HAYA VISTO EN EL PASADO:* _____ **LAST APPT THERE** / *ULTIMA CITA:* _____

HEALTH ISSUES / *HISTORIAL MEDICO PASADOS:*

(Have you ever had?) *(Alguna vez ha tenido?)*

	YES	NO
HIGH BLOOD PRESSURE / PRESION ALTA:		
HEART ISSUES / PROBLEMAS DE CORAZON:		
LUNG ISSUES / ENFERMEDAD PULMONAR:		
DIABETES / DIABETES:		
LIVER or STOMACH ISSUES / PROBLEMAS CON EL HIGADO O EL STOMAGO:		
CHRONIC JOINT OR BACK PAIN / DOLAR DE LA ESPALDO ODE ARTICULACION DE LOS HUESOS		
ANXIETY or DEPRESSION / ANSIEDAD O DEPRESION		
HISTORY OF DRUG DEPENDENCE or ABUSE / HISTORIA DE ABUSO DEPENDENCIA DE DRUGAS		

FAMILY HISTORY / *HISTORIAL MEDICO FAMILIARES*

Have any of your immediate famiy or grandparents had?

Han tenido a tienen alguin de su familia inmediata o abuels?

	YES	NO
HIGH BLOOD PRESSURE / *PRESION ALTA*		
DIABETES / *DIABETES*		
STROKE / *DERRAME CELEBRAL*		
CANCER / *CANCER*		
HEART ATTACK / *ATAQUES DE CORAZON*		
OTHER FAMILY ILLNESS: (SPECIFY) *OTRAS ENFERMEDADES FAMILIARES*		

SURGERIES / *CIRUGIAS:*

Please list any hospitalizations or surgeries:

Por favor mencionar cualquier hospitalizaciones recientes or cirugias:

DATE / *FECHA:* WHERE / *DONDE:* WHY / *MOTIVO:*

PRESENT SYMPTOMS / *SYNTOMAS PRESENTES:*

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES ____ NO ____

ES ALLERGICO A ALGUN MEDICAMENTO?

If Yes, what? / Es asi, a cual? _____

List Medication(s) Name & Dose / ***El nombre del medicamento y la dosis***

(over)

HEALTH HISTORY

	YES	NO
Do you currently smoke? / *Usted Fuma Actualente?*		
How much per day? _____		
Cuantos cigarros al dia? _____		
Have you ever quit smoking? *Alguna vez has dejado de fumar?*		
When? / *Cuando?* _____		
How many years have you smoked? / *Cuantos a nos usted fuma?* _____		

DRUGS / *CONSUMO DE DROGAS:*

	YES	NO
Do you currently use marijuana? *Acualmente usted consume marihuana?*		
Do you currently use recreational drugs? *Actualmente usted consume drogas recreativas?*		
Have you ever used needles to inject drugs? *Alguna vez has utlizado agujas para inyectarse drogas?*		

	YES	NO
Do you drink alcoholic beverages? *Usted toma bebidas alchololicas?*		

How much per week? / *Cuanto a la semana ?* _____

Beer _____ cans *Cerveza* _____ Latas
Wine _____ glasses *Vino* _____ *copas/vasoa*
Hard Liquor_____ drinks *Licor* _____ *Copitas*

	YES	NO
Do you drink caffeinated beverages? *Usted toma bebidas con cafeina?*		

How much in one week? / *Si es asi, cuanto a la semana?*

Coffee _____ cups *Café* _____ *tazas*
Tea _____ glasses *Te* _____ *vasos*
Soda _____ cans/bottles *Gaseosa* _____ *Latas / botellas*

Signed: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+
	TOTAL:			

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

PLEASE ANSWER QUESTION #10 also!

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

Shenandoah Community Health Clinic

Shenandoah County Free Clinic / Shenandoah County Dental Clinic

Patients Name _____ DOB _____

CONSENT TO EXCHANGE INFORMATION

BETWEEN HOSPITALS, HUMAN SERVICE AGENCIES, FREE CLINICS and DENTAL CLINIC

By Signing this form I am allowing the Winchester Medical Center, Shenandoah Memorial Hospital, other hospitals and other health and human services agencies to exchange certain information with the Shenandoah County Free Clinic and Shenandoah Dental Clinic and for the Clinics to exchange certain Information with Winchester Medical Center, Shenandoah Memorial Hospital and other hospitals and health and human services agencies as needed, so it will be easier for them to provide or coordinate services in a timely manner. This information includes, but not limited to, resource information; financial information; benefits/services needed; health records; billing information, employment records and eligibility for assistance programs and dates eligible.

1. I _____ am signing
   (full printed name of consenting person)

   This form for the following agencies: Winchester Medical Center and Shenandoah Memorial Hospital, other hospitals ,medical practices and health and human services agencies and the Free Clinic(s) where I am receiving health services, to share with each other the information needed as indicated above.

My Relationship to the client is ____ Self ____ Parent ____ Power of Attorney

____ Guardian ____ Other Legally Authorized Representative

Signed: _____ Date:_____

This consent may be withdrawn at any time in writing to the referring agency. This will stop the listed agencies from sharing information after they know my consent has been withdrawn. I have the right to know what information about me has been shared, and why, when and with whom it was shared. If I ask, each agency will show me this information. I want all the agencies to accept a copy of this form as a valid consent to share information