VGMHC Annual Verification Form

Virginia Garcia Memorial HEALTH CENTER

① **WHO ARE YOU? (Patient)** The information on this form should be about the patient.

First Name | Middle Name | Last Name | Suffix

Preferred Name

\- - Social Security Number (if available)

/ / Date of Birth

Veteran Status: ☐ U.S. Veteran ☐ Not U.S. Veteran

② **HOW CAN WE REACH YOU?** (Patient or the patient's parent, guardian, or authorized representative)

Address | Apartment # | City | State | Zip Code

Cell Phone | Other Phone | E-mail

Best way to contact you (mark all): ☐ Mail ☐ Phone ☐ E-mail ☐ MyChart ☐ Text Message

③ **RACE AND ETHNICITY** (this information helps Virginia Garcia make sure everyone receives access to the same care)

1. **How do you define your race, ethnicity, tribal affiliation, country of origin or ancestry?** ____________

2. **Which of the following describes your racial identity?** Please check all the apply.

Hispanic and Latino/a/x
- ☐ Central American
- ☐ Mexican
- ☐ South American
- ☐ Other Hispanic or Latino/a/x

Native Hawaiian and Pacific Islander
- ☐ CHamoru (Chamorro)
- ☐ Marshallese
- ☐ Communities of the Micronesian Region
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

White
- ☐ Eastern European
- ☐ Slavic
- ☐ Western European
- ☐ Other White

American Indian and Alaskan Native
- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Indigenous Mexican, Central American, or South America

Black and African American
- ☐ African American
- ☐ Afro-Caribbean
- ☐ Ethiopian
- ☐ Somali
- ☐ Other African (Black)
- ☐ Other Black

Middle Eastern/North African
- ☐ Middle Eastern
- ☐ North African

Asian
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Communities of Myanmar
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

Other Categories
- ☐ Other (please list) ____________
- ☐ Don't know
- ☐ Don't want to answer

3. If you checked more than one box above, is there one you think of as your primary racial or ethnic identity?

- ☐ Yes (please circle your primary racial or ethnic identity)
- ☐ I do not have one primary racial or ethnic identity
- ☐ No. I identify as Biracial or Multiracial.
- ☐ N/A. I only checked one box above.
- ☐ Don't know
- ☐ Don't want to answer

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④ Tell Us How we Can Best Serve You (this information helps Virginia Garcia provide the right resources for you)

Language

4a. What language or languages do you use at home?
____

4b. In what language do you want us to communicate in person, on the phone, or virtually with you?
____

4c. In what language do you want us to write to you?
____

5a. Do you need or want an interpreter for us to communicate with you? Interpreters are free to you.
☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer

5b. If you need or want an interpreter, what type of interpreter is preferred?
☐ Spoken language interpreter
☐ American Sign Language interpreter
☐ Deaf Interpreter for DeafBlind, additional Barriers, or both
☐ Contact sign language (PSE) interpreter
☐ Other (please list): ______________

6. How well do you speak English?
☐ Very Well ☐ Not at All
☐ Well ☐ Don't know
☐ Not Well ☐ Don't want to answer

The following questions will help us find health and service differences among people with and without functional difficulties. Your answers are confidential.

7. Are you deaf or do you have serious difficulty hearing?
☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
If yes, at what age did this condition begin? ____

8. Are you blind or do you have serious difficulty seeing, even when wearing glasses?
☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
If yes, at what age did this condition begin? ____

If patient is under 5 years old, skip to Section 5

9. Do you have serious difficulty walking or climbing stairs?
☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
If yes, at what age did this condition begin? ____

10. Because of a physical, mental or emotional condition, do you have serious difficulty concentrating, remembering or making decisions?
☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
If yes, at what age did this condition begin? ____

11. Do you have difficulty dressing or bathing
☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
If yes, at what age did this condition begin? ____

12. Do you have serious difficulty learning how to do things most people your age can learn?
☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
If yes, at what age did this condition begin? ____

13. Using your usual (customary) language, do you have serious difficulty communicating, (for example understanding or being understood by others)?
☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
☐ I don't know what this question is asking
If yes, at what age did this condition begin? ____

If patient is under 15 years old, skip to Section 5

14. Because of a physical, mental or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?
☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
If yes, at what age did this condition begin? ____

15. Do you have serious difficulty with the following: mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations?
☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
☐ I don't know what this question is asking
If yes, at what age did this condition begin? ____

⑤ Tell Us More About You (this information helps Virginia Garcia address you correctly and recommend the right care)

16. Sexual Orientation: ☐Straight or Heterosexual ☐Gay ☐Lesbian ☐Bisexual ☐Pansexual ☐Queer ☐Something else ☐Don't know ☐Choose not to answer

17. Gender Identity: ☐Female ☐Male ☐Trans Woman ☐Trans Man ☐Non-binary/genderqueer ☐Questioning ☐Choose not to answer ☐Other ________

18. Sex assigned at birth: ☐Female ☐Male ☐Intersex ☐Choose not to answer

19. Preferred Pronoun: ☐She/her ☐He/him ☐They/them ☐Use my name ☐Choose not to answer ☐Other ________

Virginia Garcia Memorial HEALTH CENTER

VGMHC Annual Verification Form

⑥ **AGRICULTURAL WORK AND HOUSING STATUS** (This information helps Virginia Garcia provide appropriate outreach services)

20. Have you or a member of your family that you live with *ever* done agricultural work as your main job?
(Agricultural work includes: work in fields, orchards, greenhouses, nurseries, fisheries, working with animals, etc.)

☐ No → **STOP (skip to question 21)**

☐ Yes → Have you or members of your family that you live with moved in the last 2 years to work in agriculture?

- ☐ Yes → **STOP** Staff mark as MFW
- ☐ No → Have you or family you live with done seasonal work in the last 2 years in agriculture without moving?
  - ☐ Yes → **STOP** Staff mark as SFW
  - ☐ No → Did you or family you live with stop working in agriculture because of disability or old age?
    - ☐ Yes → **STOP** Staff mark MFW
    - ☐ No → **STOP** Staff mark NEITHER

21. Last night did you sleep on the street, in a park, under a bridge, in a tent, in a vehicle, in a homeless camp, in a shelter, in an abandoned building, in a motel paid for by the government, in transitional housing, or with friends or family but are not a permanent resident in the home (couch surfing) or other unstable housing situation?

☐ Yes → Staff mark HMLS

☐ No → Last night were you in jail, a treatment center, hospital, or other facility with no place to go when released?

- ☐ Yes → **STOP** Staff mark HMLS
- ☐ No → **STOP** Staff mark NOT HMLS

Access to food, transportation, and other basic supports affect your health. The questions below focus on this. Your answers may help us provide better medical care and we may be able to connect you with more services.

1. What is your living situation today? (Select all that apply)			
I have a steady place to live	I have a steady place to live but I'm worried about losing it	I do not have a steady place to live	Declined

2. Within the last 12 months, you worried that your food would run out before you got money to buy more.			
Often true	Sometimes true	Never True	Declined

3. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?			
Yes, has kept me from medical appointments, or getting medications	Yes, it has kept me from non-medical meetings, appointments, work or getting things that I need	No	Declined

4. In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?			
Yes	No	Already shut off	Declined

5. How often do you see or talk to people that you care about and feel close to?				
Less than once a week	1-2 times a week	3-5 times a week	6 or more times a week	Declined

Virginia Garcia Memorial
HEALTH CENTER

PATIENT LABEL

Dental Health History/*Historia de Salud*

Name of current Primary Care Provider: ___________________________________
Nombre de su médico actual: ____
Name of Primary Medical Clinic: ____
Nombre de su clínica médica actual: ______________________________________
Clinic Phone number: ____
Teléfono de la clínica: ____
Medications Taken:
Medicamentos que está tomando:
Please list all medications (prescriptions, over the counter, and natural remedies):
Por favor díganos todos los medicamentos que toma (recetas, medicamentos sin receta, y remedios naturales):

Medical History/*Historia Médica:*

Condition		
Abuse as Adult / *Abuso en la Edad Adulta*	☐ Yes/Si	☐ No
Abuse as a Child / *Abuso en la Infancia*	☐ Yes/Si	☐ No
ADD/ADHD / *Desorden de Deficiencia de Atención/Hyperactividad*	☐ Yes/Si	☐ No
Alcoholism/*Alcoholismo*	☐ Yes/Si	☐ No
Allergies/*Alergias*	☐ Yes/Si	☐ No
Anemia / *Anemia*	☐ Yes/Si	☐ No
Anxiety / *Ansiedad*	☐ Yes/Si	☐ No
Arthritis/Joint Disorders *Artritis/Desórdenes de las articulaciones*	☐ Yes/Si	☐ No
Asthma/Asma	☐ Yes/Si	☐ No
Autism/*Autismo*	☐ Yes/Si	☐ No
Broken Jaw / *Fractura de la Mandíbula*	☐ Yes/Si	☐ No
Cancer / *Cáncer*	☐ Yes/Si	☐ No
Cataracts / *Cataracts*	☐ Yes/Si	☐ No
Clotting Disorder/ *Desórdenes de Coagulación*	☐ Yes/Si	☐ No
COPD/ *Enfermedad Pulmonar Obstructiva Crónica*	☐ Yes/Si	☐ No
Depression/ *Depresión*	☐ Yes/Si	☐ No
Diabetes	☐ Yes/Si	☐ No
Drug Addiction / *Adicción a Drogas*	☐ Yes/Si	☐ No
Have you been in an alcohol or drug rehab program?	☐ Yes	☐ No
Ha estado en un programa de rehabilitación por uso de drogas o alcohol?	☐ Si	☐ No
Emphysema/*EnfisemaPulmonar*	☐ Yes/Si	☐ No
Glaucoma/ *Glaucoma*	☐ Yes/Si	☐ No
Heart Disease/ *Enfermedades del Corazón*	☐ Yes/Si	☐ No
Heart Failure/ *Insuficiencia Cardiaca*	☐ Yes/Si	☐ No
Heart Murmur/*Soplo Cardiaco*	☐ Yes/Si	☐ No
Heart: Endocarditis / *Corazón: Endocarditis*	☐ Yes/Si	☐ No
History of Blood Transfusion / *Historia de Transfusión de Sangre*	☐ Yes/Si	☐ No
HIV/AIDS - *VIH/SIDA*	☐ Yes/Si	☐ No
Hyperlipidemia (high cholesterol)/ *Hiperlipidemia (colesterol alto)*	☐ Yes/Si	☐ No

Hypertension (high blood pressure)/ *Hipertensión (alta presión sanguínea)* ...	☐ Yes/Si	☐ No
Kidney disease/ *Enfermedad del riñón*...	☐ Yes/Si	☐ No
Liver disease (including Hepatitis A, B, and C)..	☐ Yes	☐ No
Enfermedad del Hígado (incluyendo Hepatitis A, B, y C)	☐ Si	☐ No
Meningitis	☐ Yes/Si	☐ No
Mental Health Disorder / *Desórden de Salud Mental*	☐ Yes/Si	☐ No
MRSA / SARM	☐ Yes/Si	☐ No
Myocardial Infarction (Heart Attack)/ *Infarto cardiaco (ataque al corazón)*.....	☐ Yes/Si	☐ No
Nerve/Muscle disease /*Enfermedad de los nervios o músculos*........................	☐ Yes/Si	☐ No
Osteoporosis/ *Osteoporósis*	☐ Yes/Si	☐ No
Pacemaker / *Marcapasos*	☐ Yes/Si	☐ No
Seizures/ *Ataques Epilépticos*	☐ Yes/Si	☐ No
Sickle Cell Anemia / *Anemia Drepanocítica*	☐ Yes/Si	☐ No
Sexually Transmitted Diseases (STD) / *Enfermedades de Transmisión Sexual* ...	☐ Yes/Si	☐ No
Stomach Ulcers/ *Ulceras Estomacales*	☐ Yes/Si	☐ No
Stroke/ *Derrame Cerebral*	☐ Yes/Si	☐ No
Thyroid Disease/ *Enfermedad de la Tiroides*	☐ Yes/Si	☐ No
Tuberculosis/ *Tuberculósis*..	☐ Yes/Si	☐ No

Other Medical History/*Otra Información Médica:*

Radiation/Chemo treatment - *Radiación/Quimoterapia*	☐ Yes/Si	☐ No
Tobacco use (cigarettes, pipe, cigars, smokeless tobacco) / *Uso de Tabaco*	☐ Yes	☐ No
Anticoagulation therapy (i.e. Coumadin/Warfarin)	☐ Yes	☐ No
Tratamiento con Anti-coagulantes (Coumadin/Warfarina)	☐ Si	☐ No
Bisphosphonate therapy (i.e. Fosamax, Boniva)	☐ Yes	☐ No
Terapia con Bifosfonatos (Fosamax, Boniva)	☐ Si	☐ No
Cold Sores/ *Herpes Labial*	☐ Yes/Si	☐ No
Pregnant?/ *Está embarazada?*	☐ Yes/Si	☐ No

If yes, due date: ______________ / *Si contestó "Si", cuando se alivia?* ________________

Have you had any changes to your health in the past year?	☐ Yes	☐ No
Ha tenido cambios en su salud en el último año?	☐ Si	☐ No

If yes, please explain ____

*Si contestó "Si", explique*____

Have you been hospitalized in the past year?	☐ Yes	☐ No
Ha sido hospitalizado en el último año?	☐ Si	☐ No
Have you had problems with previous dental treatment?	☐ Yes	☐ No
Ha tenido problemas con tratamientos dentales en el pasado?	☐ Si	☐ No

If yes, please explain____

Si contestó "Si", explique ____

Do you have any other medical problems not listed on this form?	☐ Yes	☐ No
Tiene otros problemas médicos no mencionados en esta forma?	☐ Si	☐ No

Other medical problems: ____

Otros problemas médicos: ____

Surgical Hx/*Historia de Cirugías:*

Joint replacement/ *Reemplazo de articulación* .... ☐ Yes/Si ☐ No
Valve replacement (heart)/ *Reemplazo de válvula del corazón*.......................... ☐ Yes/Si ☐ No

Other Surgery: ____
Otras cirugías: ____

Any relevant medical history not covered above:____
Cualquier otra información médica relevante no mencionada anteriormente: __________________________

To the best of my knowledge, I have answered every question completely and accurately.
I will inform my dentist of any changes in my health and/or medication.
He contestado las preguntas completamente y honestamente según las entiendo. Informaré a mi dentista de cualquier cambio en mi salud y/o mis medicamentos.

Patient Printed Name / *Nombre del Paciente:* ___________________________________

Patient Signature/ *Firma del Paciente*: ____ Date/*Fecha*: __________

Parent Signature/ *Firma del Padre o Guardián*: ___________________________________ Date/*Fecha*: __________

Interpreter Signature/*Firma del Intérprete:* ______________________________________ Date/ *Fecha:* __________

Provider Signature/Firma del Dentista: ____ Date/*Fecha*: __________

Virginia Garcia Memorial
HEALTH CENTER

VIRGINIA GARCIA MEMORIAL HEALTH CENTER

The Staff of the Virginia Garcia Dental Department welcomes you to our clinic. Because of the very high demand for dental services for low income and Oregon Health Plan patients, we are unable to provide services for every person who needs them. We have the following policies in order to serve as many people as possible with our limited resources. We provide comprehensive treatment for children and emergency (pain or swelling) treatment for adults.

DENTAL PATIENT POLICIES

A. The primary goal of the Dental Patient Policies of Virginia Garcia Memorial Health Center is to offer its patients an affordable and accessible mean for receiving dental services through our facilities, based on need, in accordance to the poverty income guidelines provided annually by the Federal Government.

B. A nominal fee of $30.00 dollars may apply to every visit for uninsured patients. The charges will be based on a sliding fee scale according to income. Patients with ODS, CareOregon Dental, Capitol Dental, FamilyDental Care, Open Card and private insurance should bring their most recent insurance card. Treatment costs which exceed covered fees may be the responsibility of the patient.

C. Patients who fail to show up for a scheduled appointment without giving the clinic 24 hour notice will be given a warning. If a second appointment is missed with less than one-day notice, the patient will lose appointment privileges for one year from the time of the last missed appointment and will be seen on a walk-in basis for emergency care or requiring the patient to wait on stand-by for an appointment.

D. Emergency patients who fail to show up to their scheduled follow up appointment (for treatment after the initial exam) will lose appointment privileges and will be seen only on a stand-by basis, waiting for an available opening throughout the day.

E. Please arrive 15 minutes early to your appointment. If you are late for your appointment you will be rescheduled and this will be considered to be a missed appointment.

F. We are able to provide dental care for most children. However, uncooperative children may be referred to a pediatric dentist (children's dentist).

G. If you are an adult patient receiving dental care, and bring children under 10 with you, they must wait in the lobby under the supervision of another adult (18 or older). For safety reasons, children are not allowed in the operatory while the parent/legal guardian is receiving dental care. If your child comes with you to your appointment, and you have no one to supervise him/her while you receive care, your appointment may be rescheduled.

H. In order to provide you with the best clinical care we may need to take x-rays, even if you have had them taken recently at another practice, as the American Dental Association and the Oregon Board of Dentistry recognizes this as the "Accepted Standard of Dental Care." Virginia Garcia reserves the right to refuse care if you refuse x-rays.

PATIENT LABEL

I have read these policies and by signing here I understand and will honor them.

____
Printed Name

______________________________ ____________
Signature Date

Relationship to Patient: ☐ Self ☐ Father ☐ Mother ☐ Legal Guardian