

VGMHC Annual Verification Form

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 Micronesia 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?

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

VGMHC Annual Verification Form

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 _____

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
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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
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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
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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
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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
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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:*

- 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/Hiperactividad* 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/Si No
- Ha estado en un programa de rehabilitación por uso de drogas o alcohol?* Si No
- Emphysema/*Enfisema Pulmonar*..... 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 Cardíaco* 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)/ <i>Hipertensión (alta presión sanguínea)</i> ...	<input type="checkbox"/> Yes/Si	<input type="checkbox"/> No
Kidney disease/ <i>Enfermedad del riñón</i>	<input type="checkbox"/> Yes/Si	<input type="checkbox"/> No
Liver disease (including Hepatitis A, B, and C).....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>Enfermedad del Hígado (incluyendo Hepatitis A, B, y C)</i>	<input type="checkbox"/> Si	<input type="checkbox"/> No
Meningitis	<input type="checkbox"/> Yes/Si	<input type="checkbox"/> No
Mental Health Disorder / <i>Desorden de Salud Mental</i>	<input type="checkbox"/> Yes/Si	<input type="checkbox"/> No
MRSA / SARM	<input type="checkbox"/> Yes/Si	<input type="checkbox"/> No
Myocardial Infarction (Heart Attack)/ <i>Infarto cardiaco (ataque al corazón)</i>	<input type="checkbox"/> Yes/Si	<input type="checkbox"/> No
Nerve/Muscle disease / <i>Enfermedad de los nervios o músculos</i>	<input type="checkbox"/> Yes/Si	<input type="checkbox"/> No
Osteoporosis/ <i>Osteoporosis</i>	<input type="checkbox"/> Yes/Si	<input type="checkbox"/> No
Pacemaker / <i>Marcapasos</i>	<input type="checkbox"/> Yes/Si	<input type="checkbox"/> No
Seizures/ <i>Ataques Epilépticos</i>	<input type="checkbox"/> Yes/Si	<input type="checkbox"/> No
Sickle Cell Anemia / <i>Anemia Drepanocítica</i>	<input type="checkbox"/> Yes/Si	<input type="checkbox"/> No
Sexually Transmitted Diseases (STD) / <i>Enfermedades de Transmisión Sexual</i> ...	<input type="checkbox"/> Yes/Si	<input type="checkbox"/> No
Stomach Ulcers/ <i>Úlceras Estomacales</i>	<input type="checkbox"/> Yes/Si	<input type="checkbox"/> No
Stroke/ <i>Derrame Cerebral</i>	<input type="checkbox"/> Yes/Si	<input type="checkbox"/> No
Thyroid Disease/ <i>Enfermedad de la Tiroides</i>	<input type="checkbox"/> Yes/Si	<input type="checkbox"/> No
Tuberculosis/ <i>Tuberculosis</i>	<input type="checkbox"/> Yes/Si	<input type="checkbox"/> No

Other Medical History/Otra Información Médica:

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

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

Have you had any changes to your health in the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>Ha tenido cambios en su salud en el último año?</i>	<input type="checkbox"/> Si	<input type="checkbox"/> No

If yes, please explain _____

Si contestó "Si", explique _____

Have you been hospitalized in the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>Ha sido hospitalizado en el último año?</i>	<input type="checkbox"/> Si	<input type="checkbox"/> No
Have you had problems with previous dental treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>Ha tenido problemas con tratamientos dentales en el pasado?</i>	<input type="checkbox"/> Si	<input type="checkbox"/> No

If yes, please explain _____

Si contestó "Si", explique _____

Do you have any other medical problems not listed on this form?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>Tiene otros problemas médicos no mencionados en esta forma?</i>	<input type="checkbox"/> Si	<input type="checkbox"/> 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 or Guardian 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

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 once-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



PATIENT LABEL

**Parent or Legal Guardian Consent for VGMHC to Provide
Medical and Dental Care to Minors**

Minor's Legal Name: _____

Minor's Date of Birth: _____

I hereby authorize Virginia Garcia Memorial Health Center (VGMHC) to provide medical and dental care to the above minor.

If I, or another **parent or legal guardian**, is unable to accompany the minor to VGMHC to obtain care, I authorize the following adult(s) to do so and to consent for the minor's treatment. I authorize VGMHC providers and other staff members to discuss the minor's protected confidential health information, including the treatment plan, with that adult.

Print name of person(s) authorized to accompany minor to VGMHC to obtain care.

- 1. _____ Relationship to Patient _____ Age _____
- 2. _____ Relationship to Patient _____ Age _____
- 3. _____ Relationship to Patient _____ Age _____
- 4. _____ Relationship to Patient _____ Age _____
- 5. _____ Relationship to Patient _____ Age _____

NOTE: PHOTO ID IS REQUIRED FOR EACH PERSON AT THE TIME OF THE VISIT

THIS CONSENT EXCLUDES SEDATION APPOINTMENTS

This consent will remain effective until revoked in writing.

Signature of Parent or Legal Guardian

Date

Print Name of Parent or Legal Guardian

Date