**SHENANDOAH ONCOLOGY, P.C. & VALLEY HEALTH RADIATION ONCOLOGY NEW PATIENT HISTORY FORM**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Name:** |  | | | | |  | |  | |  | |
|  | **Last First M.I.** | | | | |  | | **Today’s Date** | |  | |
|  | |  |  |  |  | |  | |  |  |  |
| **Referred By** | |  | **DOB** |  | **Marital Status** | |  | | **Height** |  | **Weight** |

**HISTORY OF PRESENT ILLNESS: Please describe the problem for which you are referred today.**

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**PAST HISTORY: If you need additional space, it is provided on the last page.**

|  |  |  |
| --- | --- | --- |
| **Surgeries (with dates)** |  | **Medical Conditions** |
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**Blood Transfusion History:**

|  |  |  |
| --- | --- | --- |
| Yes No | If yes, when? |  |

**Reproductive History:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Number of pregnancies | |  | Number of children: |  | Age at first pregnancy: |  |
| Age at first period | |  | Age at last period: |  | Are you pregnant now | Y N |
| Hysterectomy: | Y N | | Ovaries removed | Y N |  | |
| Hormone use: | Y N | | Oral contraceptive use | Y N |  | |

**Preventive Health Maintenance: Please provide dates for each answer or write “none”**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Circle One: Male OR Female** | |  |  | |
| Last mammogram: |  |  | Last Prostate exam: |  |
| Last Pap smear: |  |  | Last PSA screening: |  |
| Last colonoscopy: |  |  | Last Flu vaccine: |  |
| Last bone density scan: |  |  |  |  |
| Last pneumonia vaccine: |  |  |  |  |

**SOCIAL HISTORY**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Substance** | **Do you use?** | **What Type?** |  | **How Much?** |  | **How Often?** |  | **If quit, when?** |
| Alcohol: | Y N |  |  |  |  |  |  |  |
| Tobacco: | Y N |  |  |  |  |  |  |  |
| Caffeine: | Y N |  |  |  |  |  |  |  |
| Recreational Drugs: | Y N |  |  |  |  |  |  |  |

**FAMILY HISTORY: Please list any illnesses in your family including all cancers (i.e. breast cancer, ovarian cancer, etc.) and blood disorders (i.e. anemia, blood clotting disorders, etc.)**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Relationship** | **Illness** |  | **Diagnosis Age** | **Deceased** | **Relationship:** | **Illness** |  | **Diagnosis Age** | **Deceased** |
| Mother: |  |  |  | Y N | Brothers: |  |  |  | Y N |
| Father: |  |  |  | Y N |  |  |  |  | Y N |
| Grandmother (P): |  |  |  | Y N |  |  |  |  | Y N |
| Grandfather (P): |  |  |  | Y N | Sisters: |  |  |  | Y N |
| Grandmother (M): |  |  |  | Y N |  |  |  |  | Y N |
| Grandfather (M): |  |  |  | Y N |  |  |  |  | Y N |
|  |  |  |  |  | Children: |  |  |  | Y N |
|  |  |  |  |  |  |  |  |  | Y N |
|  |  |  |  |  |  |  |  |  | Y N |

**REVIEW OF SYSTEMS**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Constitutional** | |  | **Breast** | |  | **Skin** | |
| Weight Loss | Y N |  | Mass | Y N |  | Rash | Y N |
| Poor Energy Level | Y N |  | Pain | Y N |  | Nodules | Y N |
| Fever | Y N |  | Nipple Discharge | Y N |  | Itchiness | Y N |
| Chills | Y N |  | Change in Size | Y N |  | Lesions | Y N |
| Night Sweats | Y N |  | Change in Shape | Y N |  |  |  |
|  |  |  |  |  |  | **Neurological** | |
| **Eyes** | |  | **Gastrointestinal** | |  | Confusion | Y N |
| Double Vision | Y N |  | Nausea | Y N |  | Seizures | Y N |
| Vision Loss | Y N |  | Vomiting | Y N |  | Fainting Spells | Y N |
| Flashing Lights | Y N |  | Jaundice | Y N |  | Tremors | Y N |
|  |  |  | Abdominal Pain | Y N |  | Speech Change | Y N |
| **ENT/Mouth** | |  | Maroon/Black Stool | Y N |  | Headache | Y N |
| Ringing in Ears | Y N |  | Constipation | Y N |  | Abnormal Gait | Y N |
| Hearing Loss | Y N |  | Diarrhea | Y N |  | Weakness | Y N |
| Oral Ulcers | Y N |  | Vomiting Blood | Y N |  | Sensory Change | Y N |
| Mouth Pain | Y N |  | Difficulty Swallowing | Y N |  |  |  |
| Sore Throat | Y N |  |  |  |  | **Psychiatric** | |
| Difficulty Swallowing | Y N |  | **Urinary** | |  | Anxiety | Y N |
| Hoarseness | Y N |  | Painful Urination | Y N |  | Depression | Y N |
|  |  |  | Blood in Urine | Y N |  |  |  |
| **Cardiovascular** | |  | Increased Frequency | Y N |  | **Endocrine** | |
| Chest Pain | Y N |  | Loss of Control | Y N |  | Excessive Urine | Y N |
| Palpitations | Y N |  | Impotence | Y N |  | Excessive Thirst | Y N |
| Fainting Spells | Y N |  |  |  |  | Hot Flashes | Y N |
| Leg Swelling/Pain | Y N |  | **Gynecological** | |  | Heat/Cold Intolerance | Y N |
| Arm Swelling/Pain | Y N |  | Vaginal Discharge | Y N |  |  |  |
|  |  |  | Pelvic Pain | Y N |  | **Hematological** | |
| **Respiratory** | |  | Abnormal Bleeding | Y N |  | Nose Bleeds | Y N |
| Cough | Y N |  |  |  |  | Bleeding Gums | Y N |
| Wheezing | Y N |  | **Musculoskeletal** | |  | Easy Bruising | Y N |
| Shortness of Breath | Y N |  | Muscle Pain | Y N |  |  |  |
| Coughing Blood | Y N |  | Spine Tenderness | Y N |  | **Lymphatic** | |
| Pain with Breathing | Y N |  | Swollen Joints | Y N |  | Enlarged Lymph Nodes | Y N |
|  |  |  | Joint Redness | Y N |  | Swelling in Arms/Legs | Y N |
|  |  |  | Bone Pain | Y N |  |  |  |

**Radiation/Chemo History:**

Previous Radiation Therapy:  Yes No If yes, where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Chemotherapy: Yes No If yes, where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Preferences:**

Do you have any **special** cultural/religious belief/practices you would like the staff to be aware of? Yes No

Do you have a durable power of attorney or a living will? Yes No

Do you have a current Advanced Directive? Yes No

If Yes, please bring a copy in for our records.

If No, please let your provider know if you would like to make an appointment with a Nurse Practitioner

to complete your advance directives.

Are there any language barriers that the staff needs to be aware of? Yes No

Do you feel unsafe or threatened by anyone? Yes No

Do you have any thoughts of hurting yourself or anyone else? Yes No

**REFERRING PHYSICIANS: Please list all referring physicians and others you are currently seeing.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Physician** |  | **Address** |  | **Phone Number** |
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**PHARMACY: Please list your pharmacy information.**

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| --- | --- | --- | --- | --- |
| **Pharmacy** |  | **Address** |  | **Phone Number** |
|  |  |  |  |  |
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**Are you a veteran? Yes or No If yes, which branch of military did you serve and in what years did you serve? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever accessed the VA for any services? Yes or No If so, what services did you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you eligible for Veteran’s Benefits due to a spouse’s military service? Yes or No**

**ADDITIONAL NOTES: Please use this space to complete any additional notes that were not completed above.**

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| **Patient Signature:** | |  | | | |
|  | | | |  | |
| **Patient Printed Name:** | | |  | | |
|  | | | |  | |
| **Date:** |  | | | |



**Current Medication Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone/Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies & Adverse Reactions**

|  |  |
| --- | --- |
| Medication | Reaction |
|  |  |
|  |  |
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**Current Medications**

Prescription, over-the-counter, and herbal remedies

|  |  |  |
| --- | --- | --- |
| Medication | Dose | Schedule |
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**Reviewed By:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Acknowledgment of Receipt of Notice of Privacy Practices**

Shenandoah Oncology, P.C. is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Shenandoah Oncology, P.C.

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Representative (if appropriate):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Representative (if appropriate):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Shenandoah Oncology, P.C. Use Only**

Date acknowledgement received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OR**

Reason acknowledgement was not obtained and employee signature:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



AUTHORIZATION FOR RELEASE OF RECORDS TO

SHENANDOAH ONCOLOGY, P.C.

Medical Records Phone: 540-450-0682

Medical Records Fax: 540-667-3408

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to release information from the records of:

(Leave Blank)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address City, State, Zip Code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number

I authorize that the following records may be sent:

* Physician notes/letters
* Hospital Records
* Treatment Records
* Laboratory and Pathology results
* Pathology slides & tissue blocks
* Radiology reports and disks
* All of the above

This authorization will expire in twelve months following the date of signature, unless otherwise specified below.

Expiration Date:­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Authorization of Release of**

**Medical Information**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Shenandoah Oncology, P.C. to release information from the records of:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name Street Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Code Telephone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient

You may release this information to the following individuals:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name & Relationship Phone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name & Relationship Phone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name & Relationship Phone Number

 User Electronic Mail Authorization Form

Patient Portal: My Care Plus

My Care Plus, the Patient Portal, offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so.

Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. Please look for an email from My Care Plus promptly after submitting this form. For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician’s office in order to provide your new email information so that you will continue to receive updates and other pertinent information about the Portal or your record. Please choose an email address [one email address per patient] that will not be subject to access by anyone you do not trust.

If you wish to discontinue utilizing the Portal, please contact your physician’s office.

Terms

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic mail Authorization Form. Please write legibly.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name [printed] Email Address of Patient/Authorized User

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth of Patient Physician’s Name

Authorized user is:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Patient’s Designee’s name [Printed]

Patient’s Designee

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s medical Record Number Patient’s Designee’s Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Practice Staff Date

ATTENTION:  If you speak Spanish, Korean, Vietnamese, Chinese, Arabic, Tagalog, Persian, Amharic, Urdu, French, Russian, Hindu, German, or Bengali, language assistance services, free of charge, are available to you.  Call Front Office Supervisor at 540-662-1108

Atención: Si usted habla español, Coreano, vietnamita, Chino, Árabe, neerlandés, persa, amárico, Urdu, Francés, Ruso, hindú, alemán o bengalí, servicios de asistencia de idioma, de forma gratuita, están disponibles para usted. Llame al Supervisor de recepción en 540-662-1108

주의: 만약 당신이 말하는 스페인어, 한국어, 베트남어, 중국어, 아랍어, 타갈로그어, 페르시아어, Amhric, Urda, 프랑스어, 러시아어, 힌두교, 독일어, Dengali, 또는 크루, 언어 지원 서비스, 무료로, 당신이 사용할 수 있습니다. 티파니 Front Office Supervisor tai 540-662-1108에서 호출

Chú ý: Nếu bạn nói tiếng Tây Ban Nha, Hàn Quốc, Việt Nam, Trung Quốc, tiếng ả Rập, tiếng Tagalog, tiếng Ba tư, tiếng Amhara, tiếng Urdu, Pháp, Nga, Hindu, Đức hoặc tiếng Bengali, Dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. Gọi cho văn phòng mặt trận giám sát viên tại 540-662-1108

注意:如果您讲西班牙语、韩语、越南语、中文、阿拉伯语、塔加禄语、波斯语、阿姆法语、乌尔都语、法语、俄语、印度语、德语或孟加拉语,您可以免费获得语言协助服务。 致电前台主管 540-662-1108

تنبيه: إذا كنت أتكلم الإسبانية الكورية، الفيتنامية، الصينية، العربية، التغالوغيه، الفارسي، الأمهرية، الأردية، الفرنسية، الروسية، الهندوسية، أو الألمانية أو البنغالية، خدمات المساعدة اللغوية، مجاناً، تتوفر لك. استدعاء المشرف على مكتب الجبهة في 540-662-1108

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Front Office Supervisor (540) 662-1108

ትኩረት: እናንተ ስፓንኛ መናገር ከሆነ, ኮሪያኛ, ቬትናምኛ, ቻይንኛ, አረብኛ, ታጋሎግ, የፋርስ, አማርኛ, Urda, ፈረንሳይኛ, ሩሲያኛ, የሂንዱ, ጀርመንኛ, ቤንጋሊ, ወይም Kru, የቋንቋ እርዳታ አገልግሎቶች, ከክፍያ ነፃ, ለእርስዎ የሚገኙ ናቸው. 540-662-1108 ላይ ቲፋኒ Front Office Supervisor ይደውሉ

توجه: اگر اسپانیایی کره ای، ویتنامی، چینی، عربی، تاگالوگی، فارس، امهری، اردو، فرانسوی، روسی، هندو، آلمانی یا بنگالی حرف زبان خدمات امداد، رایگان، به شما در دسترس هستند. سرپرست دفتر جلو در 540-662-1108 تماس بگیرید

ATTENTION : Si vous parlez espagnol, coréen, vietnamien, chinois, arabe, Tagalog, persan, amharique, ourdou, Français, russe, hindou, allemand, Bengali ou Kru, services d’assistance linguistique, gratuites, sont à votre disposition. Front Office Supervisor appel à 540-662-1108

ВНИМАНИЕ: Если вы говорите, испанский, корейский, вьетнамский, китайский, арабский, тагальский, Персидский, Турецкий, урду, французский, Русский, индуистской, немецкий, бенгальский или КРУ, языковых служб помощи, бесплатно, доступны для вас. Бриден Front Office Supervisor звонка в 540-662-1108

ध्यान: यदि आप स्पेनिश, कोरियाई, वियतनामी, चीनी, अरबी, तागालोग, फारसी, Amharic, उर्दू, फ्रेंच, रूसी, हिंदू, जर्मन, या बंगाली, भाषा सहायता सेवाओं, नि: शुल्क बोलते हैं, आप के लिए उपलब्ध हैं। 540-662-1108 पर फ्रंट कार्यालय पर्यवेक्षक कॉल करें

Achtung: Wenn Sie Spanisch, Koreanisch, Vietnamesisch, Chinesisch, Arabisch, Tagalog, Persisch, Amharisch, Urdu, Französisch, Russisch, Hindu, Deutsch oder Bengali sprechen, sind Sprache Assistance-Leistungen, unentgeltlich zur Verfügung. Rufen Sie Front-Office Supervisor bei 540-662-1108

দৃষ্টি আকর্ষণ: স্প্যানিশ, কোরিয়ান, ভিয়েতনামি, চাইনিজ, আরবি, ট্যাগালোগ, পারস্য, আমহারিক, উর্দু, ফরাসি, রুশ, হিন্দু, জার্মান বা বাংলা কথা বলে। তবে ভাষা সহায়তা, ফ্রি, তোমার কাছে পাওয়া যায়। ফ্রন্ট অফিসের পরিদর্শক 540-662-1108 এ কল