



WINSLOW INDIAN HEALTH CARE CENTER DATABASE

NAME (LAST, FIRST, MIDDLE)			OTHER NAMES USED(MAIDEN NAME)			WIHCC NO.		SEX M F			
BIRTH DATE		PLACE OF BIRTH (CITY, STATE)		SOCIAL-SECURITY NO.		MARITAL STATUS		INTERNET Y N Email Address:			
CURRENT COMMUNITY		DATE MOVED		LOCATION OF HOME (DIRECTIONS TO YOUR HOME, ETC. PLEASE BE SPECIFIC.)							
MAILING ADDRESS				CITY/STATE		ZIP CODE					
HOME PHONE NUMBER			MESSAGE PHONE NUMBER			WORK PHONE NUMBER					
INDIAN BLOOD QUANTUM		TRIBE		DEGREE		CENSUS NUMBER		CIB Y N			
		OTHER TRIBE		DEGREE		RELIGION					
FATHER'S NAME			CITY OF BIRTH		STATE OF BIRTH						
MOTHER'S MAIDEN NAME			CITY OF BIRTH		STATE OF BIRTH						
EMPLOYER(IF APPLICABLE)				SPOUSE'S EMPLOYER(IF APPLICABLE)							
EMPLOYER'S ADDRESS				SPOUSE'S EMPLOYER'S ADDRESS							
EMPLOYER PHONE NUMBER				SPOUSE'S EMPLOYER PHONE NUMBER							
IF YOU ARE UNEMPLOYED, PLEASE GIVE SOURCE OF INCOME											
UNEMPLOYMENT		RETIREMENT		SSI		SSB		WELFARE		OTHER	
NAME OF EMPLOYER (FATHER)18 & UNDER				EMPLOYER ADDRESS			EMPLOYER TELEPHONE NUMBER				
NAME OF EMPLOYER (MOTHER)18 & UNDER				EMPLOYER ADDRESS			EMPLOYER TELEPHONE NUMBER				
EMERGENCY CONTACT PERSON					NEXT OF KIN CONTACT PERSON						
RELATIONSHIP		PHONE NUMBER			RELATIONSHIP		PHONE NUMBER				
ADDRESS					ADDRESS						
HEALTH INSURANCE INFORMATION											
DO YOU HAVE MEDICARE COVERAGE?				YES	NO	DO YOU HAVE RAILROAD RETIREMENT COVERAGE?				YES	NO
DO YOU HAVE AHCCCS (MEDICAID)?				YES	NO	DO YOU HAVE PRIVATE INSURANCE COVERAGE?				YES	NO
MILITARY SERVICE?		YES	NO	BRANCH		CLAIM NUMBER		ENTRY DATE		SEPARATION DATE	
VIETNAM VETERAN?				YES	NO	SERVICE CONNECTED?				YES	NO
HOUSEHOLD INFORMATION: How many family members in your household – including children?											
PLEASE READ AND SIGN CAREFULLY											
I authorize Winslow Indian Health Care Center to release any medical information or records necessary to process my Medicare, Medicaid or other insurance claims. I authorize my insurance company to pay medical benefits directly to Winslow Indian Health Care Center. If I am a non-beneficiary, I understand co-payments and deductibles will be requested at the time of service. I understand that I will be responsible for all costs if my account should be turned over to collections.											
SIGNATURE OF PATIENT, PARENT OR GUARDIAN						DATE					

Patient Medical History- Mobile Dental Clinic

WIHCC | WINSLOW INDIAN HEALTH CARE CENTER

Name: (Last, First Middle) Please Print*		Date of Birth:	School Name:
Have you been a patient in the hospital within the last two years? If YES, please write specifics of visit / admittance.			
Please list any medications and/or substances / drugs that you are now taking, or have taken in the last year. Please be specific.			
PLEASE ANSWER EACH QUESTION WITH SPECIFIC STATEMENT			
YES	NO	Are you allergic to any medications? Please list items:	
YES	NO	Heart Murmur or other Heart condition	Date of Diagnosis:
YES	NO	Heart Valve Replacement Surgery or Heart Surgery	Date of Surgery:
YES	NO	Epilepsy or Seizures	
YES	NO	Do you have Diabetes?	Have you taken your medication(s) today?
YES	NO	Artificial Joint	Which joint?
YES	NO	Asthma	
YES	NO	Sinus Trouble	
YES	NO	Kidney Disease or Dialysis	
YES	NO	Cancer or Tumors	
YES	NO	Hepatitis or Liver Disease	
YES	NO	Blood Transfusions	
YES	NO	Have you ever had any severe or uncontrolled bleeding?	
YES	NO	Have you been exposed to the AIDS Virus?	
YES	NO	Do you use alcohol or tobacco?	
YES	NO	Do you have any concerns about receiving Dental treatment?	
Please list any other medical conditions that you may have:			

FEMALES ONLY		
YES	NO	Are you Pregnant?
YES	NO	Are you on Birth Control?
Date of last Menstrual Period:		

The Photo Release is for the use of Winslow Indian Health Care Center or for any other publication(s) or purposes uses by the WIHCC now or anytime in the future. WIHCC may also use and/or publish my name in conjunction with this/these photograph(s), or use my name in an accompanying article related to the photograph, or any article(s) for WIHCC publications.

I further attest I am the parent or legal guardian and give Permission. Accept (Initial) Decline (Initial)

WIHCC DENTAL CONSENT FORM

Preventative Restoration, Standard Restorations, Fluoride Varnish Program, Periodontal Programs and Emergency dental services are available as needed. If emergency treatment is necessary informal consent will also be obtained from the child's legal guardian (parent, school, representative, etc.)

We participate in School Externship/Residencies; Dental Students & Hygiene Students may see you.

The above answers are true to the best of my knowledge. I give my consent for myself or my child under the age of 18 to receive routine care such as examinations, x-rays, cleaning or fillings and for any other type of dental care as explained by the dentist.	
Signature or Thumbprint, Parent or Legal Guardian:	Date:
Signature of Dentist:	Date:

Student Name _____

FOR OFFICE USE ONLY

Student Attendance at current school _____

Discipline(s) at current school _____

Special Services status confirmed _____

Other Notes _____

Above information verified by _____ Date _____

Accepted

Placed on Waiting List

Rejected

Reason for rejection _____

Signature of Principal

Date

Notification letter mailed emailed to parent/guardian

Date

Dorm Notification to _____

Date