WIHCC
DILKON
MEDICAL 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

PHONE NUMBER HOME CELL (CIRCLE ONE)	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

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: