



321 West Second Street

Winslow, AZ, 86047  
928-289-4441  
winslowdental@gmail.com

# WELCOME

Thank you for choosing Winslow Dental. Our goal is to provide optimal care in a comfortable and truly patient-centered environment. We promise to listen to your treatment goals and concerns. At Winslow Dental, we treat you like family and your answers are for our records only. So that we may provide exceptional care for you, please tell us about yourself:

## About You

\* Required

Patient Name\* \_\_\_\_\_ Preferred to be called\* \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Email\* \_\_\_\_\_ Cell Phone\* \_\_\_\_\_ Home Phone\* \_\_\_\_\_

Preferred Method of Contact  Phone Call  Text Message  Email  All Listed

Date of Birth\* \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy) SSN/ID\* \_\_\_\_\_

Marital Status  Single  Married  Separated  Divorced  Widowed

Sex  Male  Female

Responsible Party Name\* \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Email\* \_\_\_\_\_ Cell Phone\* \_\_\_\_\_ Home Phone\* \_\_\_\_\_

Preferred Method of Contact  Phone Call  Text Message  Email  All Listed

Date of Birth\* \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy) SSN/ID\* \_\_\_\_\_

Occupation\* \_\_\_\_\_ Employer\* \_\_\_\_\_ Work Phone\* \_\_\_\_\_

## Emergency Contact

Name\*

Phone\*

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Heart Problems/Congestive Heart Disease | <input type="checkbox"/> Deep Vein Clot              | <input type="checkbox"/> Asthma   |
| <input type="checkbox"/> Allergic to Penicillin/Amoxicillin      | <input type="checkbox"/> Hemophilia                  | <input type="checkbox"/> Sinus Trouble  |
| <input type="checkbox"/> Allergic to Tetracycline                | <input type="checkbox"/> Excessive Bleeding when cut | <input type="checkbox"/> Hay Fever  |
| <input type="checkbox"/> Allergic to Aspirin                     | <input type="checkbox"/> Sickle Cell Disease         | <input type="checkbox"/> Frequent Cough   |
| <input type="checkbox"/> Allergic to Codeine                     | <input type="checkbox"/> Glaucoma                    | <input type="checkbox"/> Rheumatism   |
| <input type="checkbox"/> Allergic to Novocain                    | <input type="checkbox"/> Diabetes (type 1 or 2)      | <input type="checkbox"/> Arthritis/Gout   |
| <input type="checkbox"/> Allergic to Latex Rubber                | <input type="checkbox"/> Excessive Thirst            | <input type="checkbox"/> Osteoporosis   |
| <input type="checkbox"/> Pre-medication required                 | <input type="checkbox"/> Scarlet Fever               | <input type="checkbox"/> Swelling of Feet/Ankles                                  |
| <input type="checkbox"/> Mitral Valve Prolapse                   | <input type="checkbox"/> Thyroid Disease             | <input type="checkbox"/> Artificial Joint Replacement:<br>Year: _____ Type: _____ |
| <input type="checkbox"/> Pacemaker                               | <input type="checkbox"/> Parathyroid Disease         | <input type="checkbox"/> Psychiatric Care   |
| <input type="checkbox"/> HIV Positive                            | <input type="checkbox"/> Kidney Disease              | <input type="checkbox"/> Epilepsy or Seizures                                     |
| <input type="checkbox"/> Heart Murmur                            | <input type="checkbox"/> Liver Disease               | <input type="checkbox"/> General Anxiety/Dental Phobia                            |
| <input type="checkbox"/> Heart Attack                            | <input type="checkbox"/> Hepatitis A or B or C       | <input type="checkbox"/> Fainting or Dizziness                                    |
| <input type="checkbox"/> Chest Pain                              | <input type="checkbox"/> Cancer, Type: _____         | <input type="checkbox"/> Hypoglycemia   |
| <input type="checkbox"/> Congenital Heart Problem                | <input type="checkbox"/> X-Ray or Cobalt Treatment   | <input type="checkbox"/> Hives  |
| <input type="checkbox"/> Artificial Heart Valve                  | <input type="checkbox"/> Chemotherapy                | <input type="checkbox"/> Cold Sores/Fever Blisters/Herpes                         |
| <input type="checkbox"/> Heart Surgery                           | <input type="checkbox"/> Ulcers                      | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> High/Low Blood Pressure                 | <input type="checkbox"/> Gastrointestinal Upset      | <input type="checkbox"/> HPV (Human Papillomavirus)                               |
| <input type="checkbox"/> Rheumatic Fever                         | <input type="checkbox"/> Acid Reflux                 | <input type="checkbox"/> Cortisone Treatment                                      |
| <input type="checkbox"/> Anemia                                  | <input type="checkbox"/> Lung Disease                | <input type="checkbox"/> Chemical Dependency                                      |
| <input type="checkbox"/> Blood Disease                           | <input type="checkbox"/> Tuberculosis                | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Blood Transfusion                       | <input type="checkbox"/> Shortness of Breath         |   |
| <input type="checkbox"/> Stroke                                  | <input type="checkbox"/> Emphysema                   |   |

Please list current medications here

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**Physician Information**

Are you currently under a physician's care? \*  Yes  No

Physician Name & Address \_\_\_\_\_

\_\_\_\_\_

If yes, for what? \_\_\_\_\_

**Hospitalization Information: If you have been hospitalized in the last two years, for what? \***

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Do you smoke or use tobacco? \* (Mark only one)  Yes  No

If yes: how many packs per day \_\_\_\_\_ Number of years as a smoker \_\_\_\_\_

Are you pregnant? * (Mark only one) <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what is your due date? ____/____/____ (mm/dd/yyyy)
Are you taking birth control pills? * <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you on hormone therapy? * <input type="checkbox"/> Yes <input type="checkbox"/> No

## Dental History

What is your primary reason for seeking dental care?

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**Previous Dentist's Information**

Dentist's Full Name \_\_\_\_\_

Name of Dental Practice _____	City & State _____
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Month and Year of last visit \_\_\_\_\_

What was done at last visit? \_\_\_\_\_

Date of last full mouth X-rays      /      /      (mm/dd/yyyy)

Reason for leaving last dentist \_\_\_\_\_

## Do You / Are You?

*Check all that apply.*

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Nervous about dental treatment?</li> <li><input type="checkbox"/> Gag easily?</li> <li><input type="checkbox"/> Sensitive to hot, cold, pressure or sweets?</li> <li><input type="checkbox"/> Have problems with teeth/fillings breaking?</li> <li><input type="checkbox"/> Have an uncomfortable bite?</li> <li><input type="checkbox"/> Have gums that are tender and/or bleed?</li> <li><input type="checkbox"/> Get food lodged between teeth often?</li> <li><input type="checkbox"/> Have periodontal (gum) treatments in the past?</li> <li><input type="checkbox"/> Get sores in or around the mouth?</li> <li><input type="checkbox"/> Get regular headaches, earaches or neck pain?</li> <li><input type="checkbox"/> Grind or clench your teeth?</li> <li><input type="checkbox"/> Hear a "clicking" sound when you open/close your mouth?</li> <li><input type="checkbox"/> Have a jaw that sometimes gets "stuck"?</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Have TMJ Jaw Disorder?</li> <li><input type="checkbox"/> Have sleep apnea?</li> <li><input type="checkbox"/> Have mouth sores that take long to heal?</li> <li><input type="checkbox"/> Have dry mouth?</li> <li><input type="checkbox"/> Have excessive bleeding after an extraction?</li> <li><input type="checkbox"/> Take Bisphosphonate medication such as Fosamax, Boniva, Actonel, Aredia, Zometa?</li> <li><input type="checkbox"/> Unhappy with the appearance of your teeth?</li> <li><input type="checkbox"/> Brush at least once daily?</li> <li><input type="checkbox"/> Want whiter teeth?</li> <li><input type="checkbox"/> Want straighter teeth?</li> <li><input type="checkbox"/> Have dentures (partials or full)?</li> <li><input type="checkbox"/> Other: _____</li> </ul> |
|--|---|

So that we can provide exceptional care, is there anything else we should know?

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Mark only one (5 is best)

- |  |                            |                            |                            |                            |                            |
|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| How do you feel your overall dental health is?                   | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| How proactive would you like to be regarding your dental health? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| Are you sensitive to dental procedures (5 is high)?              | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| Do you feel anxious about visiting the dentist (5 is high)?      | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| How do you feel about your smile and the look of your teeth?     | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

If there were anything that you would like to change about your teeth or your smile, what would that be? Please explain below:


## Dental Insurance

Do you have dental insurance? * (Mark only one) <input type="checkbox"/> Yes <input type="checkbox"/> No		
If you have dental insurance, please complete the following:		
Name of Insured		
Date of Birth	___ / ___ / ___ (mm/dd/yyyy)	Relationship to patient
Dental Insurance Company		
Group number		ID #

## Assignment & Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Winslow Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. I understand that proper diagnosis can only come after an examination is done and radiographs are taken. I hereby authorize the dentist to perform any necessary examination and radiographs needed for proper diagnosis.

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

## Referral Information

*We would love to have the opportunity to thank the person or people that have referred you to our office:*

Who can we thank for referring you to our office? \* \_\_\_\_\_

- Google search
- Facebook®
- Other: \_\_\_\_\_