



# REGISTRATION FORM

Please return this form to your school's main office.

Log # \_\_\_\_\_

## Student Information (required)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Street Address \_\_\_\_\_ Apt. Number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

School \_\_\_\_\_ Teacher \_\_\_\_\_ Grade \_\_\_\_\_

Preferred Language (if other than English) \_\_\_\_\_  Male  Female

Parent/Guardian Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Primary Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Email \_\_\_\_\_

Street Address (if different from student) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Are you interested in a free eligibility screening for state insurance (HUSKY)?  Yes  No

Would you like to receive a copy of UCFS' Notice of Privacy Practices?  Yes  No

**Race:**

American Indian/Alaskan Native

Asian

Black/African American

Native Hawaiian

Other Pacific Islander

White

More than one race

**Ethnicity:**

Hispanic or Latino

Yes  No

<b>Health History (required)</b>	<input type="checkbox"/> Anxiety/Depression	<input type="checkbox"/> Psychiatric problems	Is there anything else the hygienist should know before treating the student? _____ _____	Does the student smoke or use tobacco products? <input type="checkbox"/> Y <input type="checkbox"/> N
	<input type="checkbox"/> Asthma	<input type="checkbox"/> Respiratory Problems		
Has the student ever been treated for:	<input type="checkbox"/> Autism	<input type="checkbox"/> Rheumatic Heart Disease	Is the student currently taking any medications? <input type="checkbox"/> Y <input type="checkbox"/> N	Do the student's gums bleed while brushing or flossing? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Addiction problems	<input type="checkbox"/> Cancer	<input type="checkbox"/> Sinus Problems		
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ulcer	If yes, please list: _____ _____	Are any of the student's teeth causing him/her pain? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Allergies (please select)	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Stroke		
<input type="checkbox"/> Seasonal	<input type="checkbox"/> Fractures	<input type="checkbox"/> Thyroid Problems	Does the student require pre-medication before dental treatment? <input type="checkbox"/> Y <input type="checkbox"/> N	<b>Females only:</b> Is the student pregnant or possibly pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Latex	<input type="checkbox"/> Frequently Tired	<input type="checkbox"/> Tuberculosis		
<input type="checkbox"/> Medicine (please list)	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Tumors	Does the student have special mobility needs? <input type="checkbox"/> Y <input type="checkbox"/> N	Is the student nursing? <input type="checkbox"/> Y <input type="checkbox"/> N
_____	<input type="checkbox"/> Hearing impairment	_____		
<input type="checkbox"/> Other	<input type="checkbox"/> Hepatitis	_____	Is this the student's first visit to the dentist? <input type="checkbox"/> Y <input type="checkbox"/> N	Is the student taking birth control pills? <input type="checkbox"/> Y <input type="checkbox"/> N
_____	<input type="checkbox"/> Hives/skin rash	_____		
<input type="checkbox"/> Anemia	<input type="checkbox"/> Immune system disorder	_____		
<input type="checkbox"/> Angina	<input type="checkbox"/> Joint replacement	_____		
	<input type="checkbox"/> Kidney disease	_____		
	<input type="checkbox"/> Liver disease	_____		
	<input type="checkbox"/> Head injury	_____		
	<input type="checkbox"/> Prosthetic heart valve	_____		

**Insurance Information (required)**

Dental Insurance Company \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Company Phone \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_

Policy Holder's SS# \_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_ Employer \_\_\_\_\_

Secondary Insurance (if applicable): Insurance Company \_\_\_\_\_ ID # \_\_\_\_\_

Name of last dentist who saw your child \_\_\_\_\_ Date of last dental visit \_\_\_\_\_

Does your child have medical insurance?  Yes  No If yes, insurance name \_\_\_\_\_

Family size \_\_\_\_\_ (if a family member is pregnant, add one to total size)

Gross family income (before taxes or deductions) \$ \_\_\_\_\_ Weekly \$ \_\_\_\_\_ Monthly \$ \_\_\_\_\_ Yearly

**Required Parent Consent Section—Please Check Yes/No and Sign**

Y  N I give permission for my child to be treated and receive services deemed necessary by the staff at United Community & Family Services, Inc. ("UCFS"), including dental cleaning, fluoride treatments, examination, sealants and x-rays.

Y  N I understand that my child will receive all eligible dental services, including sealants.

Y  N I certify that the health information provided is accurate to the best of my knowledge.

Y  N I agree that messages can be left for me on the telephone number provided in the Student Information section of this form.

**Release of Information and Payment Authorization:**

Y  N I authorize the release of any medical or other information necessary to process my claim. I also authorize payment of medical benefits to UCFS for service provided.

**Consent and Acknowledgement of Privacy Practices:**

Y  N I consent to the use or disclosure of my protected health information by UCFS to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information used or disclosed by UCFS may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific authorization. I understand that information regarding how UCFS will use and disclose my information can be found in UCFS' Notice of Privacy Practices. I understand that this consent is effective for as long as UCFS maintains my protected health information. **Authorization for Exchange of Health & Education Information:** I hereby authorize UCFS to exchange health and education records with my child's school district for the purpose of providing dental care and treatment to my child.

X \_\_\_\_\_  
Signature of Parent/Legal Guardian                      Print Name of Parent/Legal Guardian                      Date