

**DEAR PARENTS/GUARDIANS,**

**U**nited Community & Family Services, Inc. (UCFS) is pleased to offer preventive dental services in your child’s school during the school day. Each child will receive a cleaning, exam, and fluoride treatment, as well as dental x-rays and sealants if needed. Your child will also learn proper brushing and flossing techniques.

All children are eligible to receive dental treatment, and UCFS accepts most insurance plans. For children without dental insurance, the cost for the above services, when provided in the school, is \$35.00. Sealants are an additional charge of \$25.00 per tooth. All services are 100% covered (no charge) for children insured by HUSKY or Medicaid. For those with other dental insur-

ance, coverage and costs depend upon your individual plan. You may call us at the number listed below with any insurance related questions.

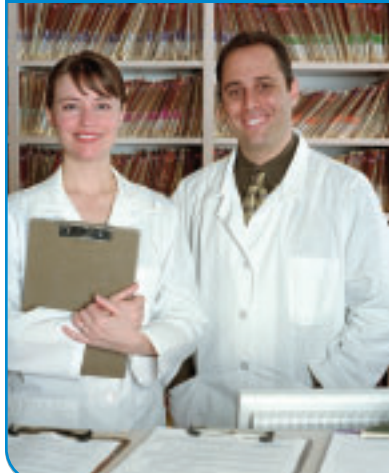
It is important for your child to receive regular preventive care. If your child is seeing the dentist regularly, keep up the good work! If not, we at UCFS encourage you to complete and return this form to your school or the address below.

**UCFS at (860) 822-4943**  
**47 Town Street**  
**Norwich, CT 06360**  
**attn: Smiles on the Move**  
**In School Dental Program**

PLEASE DETACH AND SAVE

PLEASE FILL OUT IN INK

	<b>Student Information</b>		LAST NAME		FIRST NAME		MI
	STREET ADDRESS			CITY	ST	ZIP	
	SCHOOL			TEACHER		GRADE	
	RACE		DATE OF BIRTH		SOCIAL SECURITY #		
	<input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Biracial <input type="checkbox"/> White <input type="checkbox"/> Native American <input type="checkbox"/> Other		SEX	HOME PHONE	CELL PHONE		
			<input type="checkbox"/> M <input type="checkbox"/> F				
	NAME OF RESPONSIBLE PARTY			RELATIONSHIP	WORK PHONE		
	STREET ADDRESS			CITY	ST	ZIP	
	WHERE DID YOU HEAR ABOUT US?						

	<b>Dental Billing Information</b>			PRIMARY DENTAL INSURANCE		INSURANCE/MEDICAID ID#	
	INSURANCE COMPANY PHONE		GROUP #	POLICY HOLDER'S SSN		POLICY HOLDER'S DATE OF BIRTH	
	NAME OF POLICY HOLDER			POLICY HOLDER'S EMPLOYER			
	SECONDARY DENTAL INSURANCE			INSURANCE/MEDICAID ID#			
	INSURANCE COMPANY PHONE		GROUP #	POLICY HOLDER'S SSN		POLICY HOLDER'S DATE OF BIRTH	
	NAME OF POLICY HOLDER			POLICY HOLDER'S EMPLOYER			

**Required Section – Please Fill Out Completely**

	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.		
I certify that the health information provided is accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to the student's health.		
I agree that messages can be left for me on the telephone number provided in the Student Information section of this form.		
I agree to ensure that my child receives any follow-up treatment outlined by the dental hygienist or dentist.		
I have received a copy of UCFS' Rights and Responsibilities Policy.		
<b>Release of Information and Payment Authorization:</b> 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.		
<b>Consent and Acknowledgement of Privacy Practices:</b> 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.		
<b>Authorization for Exchange of Health &amp; Education Information:</b> 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.		
	<b>SCHOOL DISTRICT</b>	
This authorization is valid while my child is enrolled in the above school district. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care. I agree that a copy of this authorization is as valid as the original.		
By signing below, I understand and acknowledge the following: 1) I have read and understand this consent; and, 2) I have received UCFS' Notice of Privacy Practices currently in effect.		
<b>PRINT NAME OF INDIVIDUAL OR PERSONAL REPRESENTATIVE</b>	<b>X</b>	
	<b>SIGNATURE</b>	<b>DATE</b>

# Health Information

STUDENT NAME	LOG NUMBER

## Medical and Dental Information

PHYSICIAN'S NAME	PHYSICIAN'S PHONE
NAME OF LAST DENTIST	DENTIST'S PHONE
DATE OF LAST PHYSICAL EXAM	DATE OF LAST DENTAL VISIT

Has the student ever been treated for or is currently being treated for:

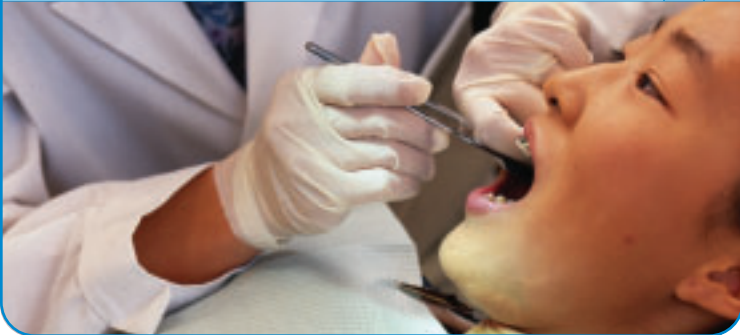
CONDITION	Y	N	CONDITION	Y	N
Addiction Problems			Joint Replacement		
Allergies			Kidney Disease		
Anemia			Liver Disease		
Angina			Low Blood Pressure		
Asthma/Hay Fever			Osteoporosis		
Cancer			Head Injury		
Diabetes			Prosthetic Valve		
Emphysema			Psychiatric Problems		
Epilepsy/Convulsions			Radiation Therapy		
Fainting/Seizures			Respiratory Problems		
Fractures			Rheumatic Heart Disease		
Frequently Tired			Sinus Trouble		
Heart Murmur			Ulcer		
Hepatitis			Stroke		
High Blood Pressure			Thyroid Problems		
Hives/Skin Rash			Tuberculosis		
Immune System Disorder			Tumors		



## Student Medication Information

	Y	N
Does the student have any allergies to medications? If yes, please list:		
Please list any medications the student is currently taking:		

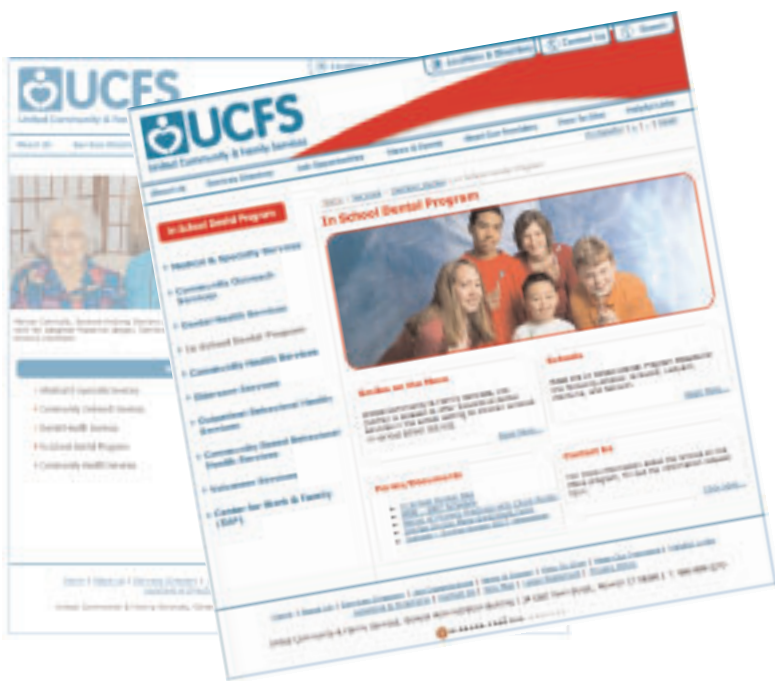
	Y	N
Does the student smoke or use chewing tobacco products?		
Do the student's gums bleed while brushing or flossing?		
Are any of the student's teeth causing him/her pain?		
Is there anything else that you think the dental hygienist should know before treating the student? (fear of dentist, etc.) If yes, explain:		
Females Only:		
Is the student pregnant or possibly pregnant?		
Is the student nursing?		
Is the student taking birth control pills?		



OFFICE USE ONLY	
PROVIDER SIGNATURE	DATE
REASON NOT SEEN	STAFF

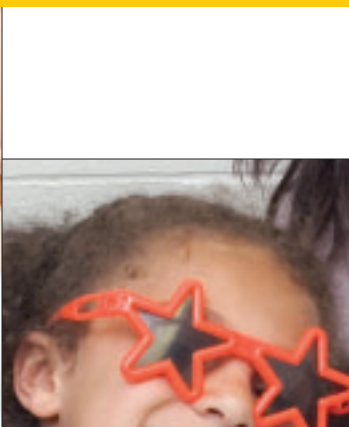


Please visit our website at [www.ucfs.org](http://www.ucfs.org) to view the current Smiles on the Move schedule and learn more about other valuable programs offered by UCFS.



cover photo of girl with star glasses  
©2005Gale Zucker/www.gzucker.com

★ FIRST TIME ENROLLMENT ★



**Smiles on the Move**  
IN SCHOOL DENTAL PROGRAM

