



REGISTRATION FORM

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

Student Information (required)

Log # _____

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

Do you have another child in the same school district that you would like to register? Yes No

If yes, please complete a separate registration form for each child you would like to register.

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

Health History (required) section containing various medical conditions and questions about dental treatment, medications, and allergies.

Insurance Information (required) section containing fields for dental insurance company, policy holder, SS#, DOB, and income.

Parent Consent Section (required) — Please Check Yes/No and Sign

- Consent questions: I give permission for my child to be treated... I understand that my child will receive all eligible dental services... I certify that the health information provided is accurate... I agree that messages can be left for me...

Release of Information and Payment Authorization:

- 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:

- 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...

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