



REGISTRATION FORM

Log # _____

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

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
Home Phone Work Phone Cell Phone
Primary Phone Email

Street Address (if different from student) City State Zip

Are you interested in a free eligibility screening for state insurance (HUSKY)?
Would you like to receive a copy of UCFS' Notice of Privacy Practices?
Do you have another child in the same school district that you would like to register?

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

Race: Please select all that apply. American Indian/ Alaskan Native, Asian, Black/African American, Native Hawaiian, Other Pacific Islander, White. Ethnicity: Hispanic or Latino Yes No. Gender Identity: Male, Female, Transgender Male/Female-to-Male, Transgender Male/Male-to-Female, Other, Chose not to disclose. Sexual Orientation: Lesbian or Gay, Straight (not Lesbian or Gay), Bisexual, Something else, Don't know, Chose not to disclose.

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 #
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

Health History (required)
Has the student ever been treated for: Addiction problems, ADD/ADHD, Anemia, Angina, Anxiety/Depression, Asthma, Autism, Cancer, Diabetes, Epilepsy/Seizures, Fractures, Frequently Tired, Heart murmur, Hearing impairment.
Hepatitis, Hives/skin rash, Immune system disorder, Joint replacement, Kidney disease, Latex allergy, Liver disease, Head injury, Prosthetic heart valve, Psychiatric problems, Respiratory Problems, Rheumatic Heart Disease, Seasonal allergies, Sinus Problems, Ulcer, Stroke, Thyroid Problems.
Tuberculosis, Tumors.
Does the student have special mobility needs? Yes No
Is this the student's first visit to the dentist? Yes No
Does the student require pre-medication before dental treatment? Yes No
Is there anything else the hygienist should know before treating the student?
Is the student currently taking any medications? (please list)
Is the student allergic to any medications? (please list)
Does the student smoke or use tobacco products? Yes No
Do the student's gums bleed while brushing or flossing? Yes No
Are any of the student's teeth causing him/her pain? Yes No
Females only: Is the student pregnant or possibly pregnant? Yes No
Is the student nursing? Yes No
Is the student taking birth control pills? Yes No
Name of last dentist who saw your child:
Date of last dental visit:

Parent Consent Section (required) - 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, screening, 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.
Y N I understand I am responsible to pay for the services rendered if I do not have insurance. \$40 includes screening, cleaning, fluoride and x-rays, Sealants are a separate charge of \$30 per tooth.

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