Please complete all sections on both sides * IN INK *

Smiles on the Move
IN-SCHOOL DENTAL PROGRAM

REGISTRATION FORM

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

For more information:
call (860) 822-4943
or visit UCFShealthcare.org

UCFS Healthcare

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

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

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)? □ 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.

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?

□ Y □ N

_____

_____

Is this the student's first visit to the dentist?

□ Y □ N

Does the student require pre-medication before dental treatment?

□ Y □ N

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?

□ Y □ N

Do the student's gums bleed while brushing or flossing?

□ Y □ N

Are any of the student's teeth causing him/her pain?

□ Y □ N

Females only:

Is the student pregnant or possibly pregnant?

□ Y □ N

Is the student nursing?

□ Y □ N

Is the student taking birth control pills?

□ Y □ N

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, 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.

□ Y □ N I understand I am responsible to pay for the services rendered if I do not have insurance. $40 includes exam, 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**