(570) 645-2044
www.VermillionDental.com

VERMILLION
DENTAL OFFICE

39 W. Ludlow St.
Summit Hill PA 18250

Child Personal Information

Name: _____

Date of Birth: _____

Social Security Number: _____

□ Male □ Female

If a student, name of school or college:

_____

Financial and Billing Information

Responsible Party *(person responsible for financial obligations)*: □ Check if same as patient

_____

Relationship of responsible party to patient:

_____

Social Security Number: _____

Home address of responsible party:

_____

_____

Phone number of responsible party:

_____

Contact Information

Mailing address: _____

_____

Emergency Contact:

_____

Name *Phone*

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Preference for appointment reminders: □ Home Phone □ Cell Phone □ Email □ Text

Is it OK to leave messages on your voicemail and/or answering machine? □ Yes □ No

Please check below the names of the persons you permit us to discuss your treatment and billing with:

□ parents □ children

Acknowledgement of Receipt of Notice of Privacy Practices

I have had full opportunity to read and consider the contents of this office's Notice of Privacy Practices. I understand that, by signing this form I am giving consent to use and disclose my protected health information to carry out treatment, payment activities, and health care operations. I understand I may refuse to sign this acknowledgement.

Signature of parent/guardian Date