(570) 645-2044
www.VermillionDental.com

VERMILLION
DENTAL OFFICE

39 W. Ludlow St.
Summit Hill PA 18250

Personal Information

Name: ________________________________

Date of Birth: __________________________

Social Security Number: _________________

□ Male □ Female

□ Minor □ Single □ Married

Spouse: ______________________________

Parents / Guardian *(if a minor)*:

____

Employer: ____________________________

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 □ spouse □ boyfriend/girlfriend □ other ___________________________

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 patient/parent Date