Ronald N. Cummings, D.D.S., M.S.

Orthodontics / Adults / Teenagers & Children

PATIENT INFORMATION

Patient's Name_____

Address_____

Home Phone_____ Birthdate_____ Social Security #_____

If patient is a minor, give parent or guardian's name_____

How did you hear of our office?_____

Siblings_____

RESPONSIBLE PARTY INFORMATION

Name_____

Residence_____

Mailing Address_____

How long at this address_____ Home Phone_____ Work Phone_____

Previous Address (if less than 3 years)_____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed _____

Spouse's Name_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed _____

Social Security #_____ Birthdate_____ Work Phone_____

INSURANCE INFORMATION

Insured's Name_____ Insured's Social Sec. #_____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address_____

Insured's Employer_____

Do you have dual coverage? Yes ☐ No ☐ If yes:

Insured's Name_____ Insured's Social Sec. #_____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address_____

Insured's Employer_____

EMERGENCY INFORMATION

Name of nearest relative not living with you_____

Complete Address_____

Phone_____