

# 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 \_\_\_\_\_

