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

Orthodontics / Adults / Teenagers & Children

Member
American Association of
Orthodontists

1378 Timberlane Road • Tallahassee, Florida 32312 • (850) 893-5018

Tell Us About Your Child

Today's Date: _____

Child's Name: _____

Nickname: _____ ❑ Male ❑ Female

Birthdate: _____ Age: _____

School: _____ Grade: _____

Hobbies/ Sports: _____

Child's Home #: _____

Child's Home Address: _____

_____

Person Responsible For Account

Name: _____ Relation: _____

Billing Address: _____

_____

Previous Address: _____

(If less than 3 years)

_____

_____

Wk #: _____ Ext: _____ Hm #: _____ Employer:

SS#: _____ _____

Who is responsible for making appointments?

Name: _____

Wk #: _____ Ext: _____ Hm #: _____

Who Is Accompanying Your Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ❑ Yes ❑ No

Whom may we Thank for referring you? _____

List brothers/sisters with age: _____

_____

General Dentist: _____

Last visit date: _____

Parents Marital Status: ❑ Single ❑ Widowed

❑ Married ❑ Divorced ❑ Separated

Orthodontic Insurance

Primary Orthodontic Insurance

Orthodontic Coverage: ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group #(Plan, Local or Policy #): _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate: ___/___/____ Insured SS#: _____

Insured's Employer: _____

Mother's Information: ❑ Step Mother ❑ Guardian

Name: _____ Birthdate: __/__/_____

Wk #: _____ Ext: _____ Hm #: _____

Employer: _____

How long at current job: _____ Job title: _____

SS#: _____

Father's Information: ❑ Step Father ❑ Guardian

Name: _____ Birthdate: __/__/____

Wk #: _____ Ext: _____ Hm #: _____

Employer: _____

How long at current job: _____ Job title: _____

SS#: _____

Primary Orthodontic Insurance

Orthodontic Coverage: ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group #(Plan, Local or Policy #): _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate: ___/___/____ Insured SS#: _____

Insured's Employer: _____