THREE RIVERS ENDODONTICS

PATIENT INFORMATION

Date: ______________________ ☐ Miss ☐ Ms. ☐ Dr. ☐ Mx. ☐ Mrs. ☐ Mr. ☐ __________

Patient Name: ____
Last *First* *M.I.* *(Preferred Name)*

Social Security #: ______________________ Date of Birth: ______________________

Sex: ☐ Male ☐ Female ☐ Non Binary ☐ __________

Pronoun: ☐ He ☐ She ☐ They ☐ __________

☐ Married ☐ Single ☐ __________

Email Address: ____

Phone #: ____
Home *Cell* *Work*

Address: ____
Street *City* *State* *Zip*

Name of Referring Dentist: ______________________ Phone #: ______________________

Responsible Party Information *(If other than the Patient)*

Name: ______________________

Responsible Party is: ☐ Patient's Spouse ☐ Patient's Parent ☐ Other (*please specify*) __________

Social Security #: ______________________ Date of Birth: ______________________

Email Address: ____

Phone #: ____
Home *Cell* *Work*

Address: ____
Street *City* *State* *Zip*

Emergency Contact Information

In the event of an emergency, who should we contact? ______________________

Relationship : ____

Phone # : ____
Home *Cell* *Work*