DR. BRADFORD l. RABE
Rabe Family Dentistry, P.C.
550 SE Baseline Hillsboro, Oregon 97123

Patient Information:

First Name: _____ Last Name: _____ Preferred Name: _____

Address:_____

City, State, Zip: _____

Home Phone: _____Work Phone: _____ Cell:_____

Birth Date: _____ Soc Sec #:_____ Drivers License: _____

E-mail Address _____

Sex: □ Male □ Female Marital Status: □ Married □ Single □ Other

I have Read & Understand the Office Policies:
Signature:_____ Date:_____
Emergency Contact Name & Phone #:_____
Relationship to Patient:_____
Who may we thank for referring you to our office? : _____
Physician's Name & Phone #:

Preferred Pharmacy:

Name:_____ Location (intersection): _____

Responsible Party: (if different than patient)

Relationship to Patient: □ Spouse □ Parent □ Other _____

First Name: _____ Last Name: _____

Address (if different from above):_____

City, State, Zip: _____

Home Phone: _____ Cell:_____

Dental Insurance Information:

Insurance Company Name: _____

Ins. Company Address: _____

Phone Number: _____

Employer: _____ Group #: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Soc. Sec. # or Member ID: _____