



DR. RONALD B. 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: _____