DR. STEFANIE M. BECKLEY
Rabe & Beckley 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

Emergency Contact Name:____

Relationship to Patient:____

Emergency Phone #:____

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: _____________________________