

# WELCOME

TO  
RESTORATIVE ARTS DENTAL  
G. E. RABON, D.M.D.

## ABOUT YOU

Date \_\_\_\_\_  
Full Name \_\_\_\_\_ Preferred Name \_\_\_\_\_  
Birth date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ SS# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Email address \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Spouse/Parent Information

If patient is a child please fill out the following information for parents

Name \_\_\_\_\_ Birth date \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Work Phone \_\_\_\_\_ Social Security # \_\_\_\_\_

## In Case Of An Emergency Please Contact

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Who may we thank for referring you to our office \_\_\_\_\_

**Our goal is to give our patients the best dental care possible.  
We strive to make each visit a pleasant and educational one.  
Thank you for choosing Restorative Arts Dental to meet your  
dental needs.**