

# PLEASE COMPLETE THE FOLLOWING

**Daniel R. Roth, D.M.D.**  
FAMILY DENTISTRY

North 10010 Division Street  
Spokane, WA 99218-1305  
(509) 466-2587

## GENERAL INFORMATION

- Dr.
- Mr.
- Mrs.
- Ms.

\_\_\_\_\_ Last First Middle SS # Birthdate

Residence Address \_\_\_\_\_  
Number Street City Zip Code Area Code Telephone

If less than one year, previous address \_\_\_\_\_

Business Address \_\_\_\_\_  
Employer Street City Zip Code Area Code Telephone

Marital Status \_\_\_\_\_ Name of Spouse \_\_\_\_\_

Spouse's Occupation \_\_\_\_\_ Employer \_\_\_\_\_

If patient is a minor, who is legally responsible? \_\_\_\_\_  
Name

\_\_\_\_\_ Address Area Code Telephone

By whom were you referred? \_\_\_\_\_ When? \_\_\_\_\_

## INSURANCE INFORMATION

If you have any type of dental insurance, please complete the following.  
If not, please complete the information concerning your health on the back page.

Name and address of Insurance Carrier: \_\_\_\_\_

Employer: \_\_\_\_\_ Group Number: \_\_\_\_\_

Employee: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Relationship of patient to employee: \_\_\_\_\_

Employer address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

If covered by a second insurance plan, please fill out the following:

Name and address of Insurance Carrier: \_\_\_\_\_

Employer: \_\_\_\_\_ Group Number: \_\_\_\_\_

Employee: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Relationship of patient to employee: \_\_\_\_\_

**NOTICE: We keep a record of the health care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.**