



**Goldsboro Dental Arts**  
**Shaun White, DMD**

We are pleased to have you as a guest in our practice. Please take a few minutes to fill this form (front/back) as completely as you can. If you have any questions, please feel free to ask. We look forward to being of service to you.

**Patient Info:**

Name: \_\_\_\_\_ Soc Sec #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Sex: Male/Female Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Single/Married/Divorced/Widowed

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

How do you plan to pay for today's visit? Cash/Check/Master/Visa

How did you hear about us? Phonebook referral? - Whom: \_\_\_\_\_ Other: \_\_\_\_\_

**Dental Insurance:**

Person Responsible for acct: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Soc Sec #: \_\_\_\_\_

Responsible party's employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_

Name(s) of other dependents under this plan: \_\_\_\_\_

**Please complete below if patient is a minor (under 18 years of age)**

Mother Name: \_\_\_\_\_ Soc Sec #: \_\_\_\_\_ DOB: \_\_\_\_\_ Work #: \_\_\_\_\_

Father Name: \_\_\_\_\_ Soc Sec #: \_\_\_\_\_ DOB: \_\_\_\_\_ Work #: \_\_\_\_\_