Green Hills
DENTAL GROUP
John L. Farringer III, D.D.S.

Today's Date:_____

Name _____ SS#_____
Address _____
City _____ State _____ Zip_____
Home Phone_____Work Phone_____ Cell_____
Birthdate_____Age_____ Sex □ F □ M
□ Married □ Widowed □ Divorced □ Seperated □ Single □ Partnered
Employer/School_____ Occupation_____
Spouse's Name_____ SS#_____
Spouse's Birthdate_____
Emergency Contact:_____ Phone#_____

Whom May We Thank for Referring You?_____

Dental Insurance:

Primary Insurance Company_____Subscriber's Employer_____
Subscriber's Name_____Birthdate_____Relation_____
Insurance Address _____ Phone #_____
Patient Identification #_____ Group# _____

Secondary Insurance Company_____
Subscriber's Name_____Birthdate_____Relation____
Insurance Address _____ Phone #_____
Patient Identification #_____ Group# _____

Medical Insurance: (for TAP and TMJ appliances)

Primary Insurance Company_____
Subscriber's Name_____Birthdate_____Relation____
Insurance Address _____ Phone #_____
Patient Identification #_____ Group# _____

Secondary Insurance Company_____
Subscriber's Name_____Birthdate_____Relation____
Insurance Address _____ Phone #_____
Patient Identification #_____ Group# _____