Victor Valley Endodontics

17260 Bear Valley Road, Suite 108
Victorville, California 92392

PATIENT INFORMATION (Please Print)

Title: _____ First Name: _____ MI: _____ Last Name: _____
Nick Name (What do you like to be called?): _____
Birthdate: _____ Soc. Sec.: _____ Gender: ☐ Male ☐ Female
Address: _____ Apt./Suite: _____
City: _____ State: _____ Zip Code: _____
Phones: Home: _____ Work: _____ Ext.: _____
Mobile: _____ Fax: _____ Email: _____
Employer: _____ Phone: _____ Occupation: _____
Referred By: _____ General Dentist: _____
Have you been seen in this practice before today? ☐ Yes ☐ No

PERSON RESPONSIBLE FOR ACCOUNT (if other than patient)

Title: _____ First Name: _____ MI: _____ Last Name: _____
Relationship to Patient: ☐ parent ☐ spouse ☐ child ☐ other _____ please specify Soc. Sec.: _____
Address: _____ Apt./Suite: _____
City: _____ State: _____ Zip Code: _____
Phones: Home: _____ Work: _____ Ext.: _____
Mobile: _____ Fax: _____ Email: _____
Employer: _____ Phone: _____ Occupation: _____

DENTAL INSURANCE INFORMATION

Primary Insurance
Ins. Co.: _____
Group No.: _____ Phone: _____
Employer: _____
Employee (if other than patient)
Name: _____
Birthdate: _____ Soc. Sec.: _____
Subscriber No.: _____ ☐ Male ☐ Female

Secondary Insurance
Ins. Co.: _____
Group No.: _____ Phone: _____
Employer: _____
Employee (if other than patient)
Name: _____
Birthdate: _____ Soc. Sec.: _____
Subscriber No.: _____ ☐ Male ☐ Female

CONSENT

I authorize Victor Valley Endodontics to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or health practitioners. I authorize and hereby request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents. Permission is granted to Victor Valley Endodontics and his staff to perform procedures, including the giving of anesthetics or the taking of radiographs that may be necessary for my dental treatment. I have the right to refuse any procedure. I will be responsible if I terminate treatment against dental advice.

_____ _____ _____ _____
Signature (parent or guardian if patient is a minor) Date Signature of authorized representative of Victor Valley Endodontics Date