Brian R. Papworth, DDS, MS

PATIENT REGISTRATION
(PLEASE PRINT)

Full Name_______________________________________Date of Birth_______________Age__________

Home Address______________________________City____________________State________Zip___________

P.O. Box__________________________________City____________________State________Zip___________

Home Phone_________________Cell Phone_________________E-Mail_____________________________

Check Approved Methods of Contacting You: ___Home Phone ___Cell Phone ___E-Mail ___Work

Social Security Number_______________ Driver's License Number_________________Male___Female___

Name of Spouse or Partner_____________________________Phone_____________________

Your Employer___________________________Work phone_____________________________

Emergency Contact___________________________Relation to Patient_______________Phone______________

Our office bills individuals in the same household under one account. If you need to have separate accounts please notify us. **Payment is due upon receipt of services.** As a courtesy to our patients we will bill private dental insurance claims. However, the co-payment and/or deductible specified by your dental plan are due at the time of service. Please remember that you are ultimately responsible for payment of all services. Payments may be made by cash, check, all major credit cards.

Authorization for Release of Dental Information/Assignment of Benefits
I authorize Papworth Endodontics to release dental information for insurance purposes concerning treatment for myself or the above named patient while under his care. I agree to pay any fees not covered by my insurance.

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ENDODONTICS

Patient/Guardian Signature________________________________**Date**____________________