Joseph B. Suffridge, D.D.S., P.A.
Practice Limited to Endodontics
707 W. Faulkner
El Dorado, AR 71730
419 Highway 5 North
Benton, AR 72019

PATIENT INFORMATION (Please Print)

Title: _____ First Name: _____ MI: ____ Last Name:_____

Birthdate: _____ Soc. Sec.: _____ Gender:_____

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:_____

Birthdate: _____ Soc. Sec.: _____ Relationship to Patient: _____

Address: _____ Apt./Suite: _____

City: _____ State: _____ Zip Code: _____

Phones: Home: _____ Work: _____ Ext. _____

Mobile: _____ Fax: _____ Email: _____

Employer: _____ Phone: _____ Occupation: _____

Emergency Name: _____ Phone:_____ Relationship:_____

HIPPA – Notice of Privacy Practices Act for Dentists

Notice of Privacy Practices describes how health information about you may be used and disclosed and how you can get access to this information. A copy of the Notice of Privacy Practices pamphlet is located at the front desk for your review. We encourage you to review it carefully. The privacy of your health information is very important to us. We use and disclose health information about you for treatment, payment, and healthcare operations to a physician or other healthcare provider providing treatment to you. We must disclose your health information to you, as described in the Patients Rights section of the Notice of Privacy Practices pamphlet. We may only disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. Please list below the name and relationship of the person(s) other than your healthcare provider you are giving our office the consent to disclose your protected health information. By signing this consent form, you are giving our office the consent to use and disclose your protected health information to carry out treatment, payment activities and healthcare operations. You have the right to revoke this consent at any time by giving us written notice of your revocation.

_____ _____ _____ _____

Signature (Parent or Guardian if patient is a minor) Date Signature of authorized representative of Joseph B. Suffridge, DDS, PA Date