PATIENT REGISTRATION FORM

PATIENT NAME ____________________
ADDRESS ____________________ E-MAIL ____________________
CITY ____________________ STATE __________ ZIP ____________________
HOME PHONE ____________________ WORK PHONE ____________________ CELL ____________________
BIRTHDAY ____________________ SEX M F
SOC. SEC. # ____________________ MARITAL STATUS ____________________
EMPLOYER ____________________ HOW LONG (Employed) ____________________
SPOUSE ____________________ EMPLOYER ____________________
EMERGENCY CONTACT PERSON ____________________ PHONE ____________________
REFERRING DENTIST ____________________

INSURED OR RESPONSIBLE PARTY INFORMATION

NAME ____________________ RELATIONSHIP ____________________
ADDRESS ____________________ CITY, STATE, ZIP ____________________
SOC. SEC. # ____________________ PHONE # ____________________
BIRTHDATE ____________________ EMPLOYER ____________________

I WILL BE PAYING TODAY BY: CASH __________ CHECK __________ VISA/MC/DISC/AMEX __________

DENTAL INSURANCE CO. ____________________
ADDRESS ____________________ CITY, STATE, ZIP ____________________
PHONE# ____________________ GROUP# ____________________
SUBSCRIBER NAME ____________________ ID# ____________________

(SECONDARY COVERAGE)
INSURANCE CO. ____________________
ADDRESS ____________________ CITY, STATE, ZIP ____________________
PHONE# ____________________ GROUP# ____________________
SUBSCRIBER NAME ____________________ ID# ____________________

I UNDERSTAND AND AGREE THAT REGARDLESS OF INSURANCE STATUS, I AM COMPLETELY RESPONSIBLE FOR PAYMENT OF MY ACCOUNT FOR SERVICES RENDERED. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. THIS SIGNATURE ON FILE IS MY AUTHORIZATION FOR THE RELEASE OF INFORMATION NECESSARY TO PROCESS ANY OF THE INSURANCE BENEFITS. MY SIGNATURE AUTHORIZES THAT ALL INSURANCE BENEFITS ARE TO BE MADE PAYABLE DIRECTLY TO DR. PULSIPHER. THIS OFFICE RESERVES THE RIGHT TO VERIFY THE CREDIT STATUS OF POTENTIAL PATIENTS AND/OR PARENTS OF THE PATIENT PRIOR TO EXTENDING CREDIT FOR TREATMENT. AT THE DISCRETION OF THE OFFICE, WE MAY USE THE SERVICES OF ONE OR MORE CREDIT REPORTING SERVICES.

SIGNATURE ____________________ DATE ____________________

PATIENT HEALTH QUESTIONNAIRE

ARE YOU UNDER MEDICAL TREATMENT NOW? YES NO
IF YES EXPLAIN ______
ARE YOU TAKING ANY MEDICINES? YES NO
IF YES LIST ______

HAVE YOU EVER TAKEN PHEN-FEN/REDUX (DIET PILLS) YES NO

WOMEN ONLY

ARE YOU PREGNANT? YES NO
ARE YOU ON BIRTH CONTROL? YES NO
ARE YOU NURSING? YES NO

ARE YOU ALLERGIC OR HAD A REACTION TO ANY OF THE FOLLOWING?

LOCAL ANESTHETICS ______
SULFA DRUGS ______
PENICILLIN ______
OTHER ANTIBIOTICS ______
IODINE ______
ASPIRIN ______
CODEINE ______
LATEX RUBBER ______
BLEACH ______
OTHER ______
ANY METALS (MERCURY, NICKEL, ETC.) ______

CHECK ANY OF THE FOLLOWING WHICH PERTAIN TO YOU PAST OR PRESENT

HIGH BLOOD PRESSURE ______
LOW BLOOD PRESSURE ______
RHEUMATIC FEVER ______
KIDNEY DISEASE ______
THYROID PROBLEM ______
HEART MURMUR ______
EMPHYSEMA ______
ARTIFICIAL JOINTS ______
CHEST PAINS ______
HAY FEVER/ALLERGIES ______
RADIATION OR CHEMOTHERAPY ______
MITRAL VALVE PROLAPSE ______
HEART ATTACK ______
LEUKEMIA ______
AIDS/HIV/STD'S ______
HEART DISEASE ______
ANGINA ______
CANCER ______
HEPATITIS/JAUNDICE ______
STROKE ______
GLAUCOMA ______
RESPIRATORY PROBLEMS ______
ASTHMA/EASILY WINDED ______
EPILEPSY ______
DIABETES ______
PACEMAKER ______
ANEMIA ______
ARTHRITIS ______
ULCERS/STOMACH PROBLEMS ______
TUBERCULOSIS ______
LIVER DISEASE ______
FAINTING/FREQUENTLY TIRED ______
SWOLLEN ANKLES/WEIGHT LOSS ______
OTHER ______

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH, I HAVE INFORMED DR. PULSIPHER OF ALL MEDICAL INFORMATION. I AUTHORIZE THE DR. TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT RENDERED TO ME OR MY CHILD TO THIRD PARTY PAYORS OR HEALTH PRACTITIONERS.

SIGNATURE ______ DATE ______

Dr. Craig D. Pulsipher, DDS PA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I have received a copy of this office's Notice of Privacy Practices.

Signature: Date:

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify) ____________________

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

208-734-7450 • Fax 208-734-7484 • 142 River Vista Place • Twin Falls, ID 83301

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ____________________ Date: ____________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____________________

Relationship to Patient: ____________________

Revocation of Consent
I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.
I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ____________________ Date: ____________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

ENDODONTIC INFORMATION AND CONSENT FORM FOR DR. CRAIG PULSIPHER

We would like you to be fully informed about the various procedures involved in endodontic therapy and we require their written consent before starting treatment. Root canals are performed in order to save a tooth which otherwise might need to be removed. The following discusses possible risks that may occur from endo treatment and other choices.

GENERAL RISKS OF DENTAL CARE: Included (but not limited to) are complications resulting from the use of dental instruments and medicines such as: antibiotics, pain pills and local anesthetics. These complications may include: swelling, sensitivity, bleeding, pain, infection, numbness and tingling in the lip, tongue, chin, gums, cheeks and tooth which are momentary but on infrequent occasions may be longer lasting or permanent; reaction to referred pain to ear, neck and head; nausea, vomiting, allergic reactions, delayed healing, sinus perforations and treatment failure.

RISKS MORE SPECIFIC TO ENDO THERAPY: The risks include the possibility of instruments broken within the canal, perforations (extra openings) of the crown or root of the tooth, damage to bridges, existing fillings, crowns or porcelain veneers, loss of tooth structure in gaining access to canals and cracked teeth. During treatment complications may be discovered which make treatment impossible or which may require corrective dental surgery. These complications may include: blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease or fractured teeth.

MEDICATIONS: Some prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effects. Some antibiotics may interfere with the effectiveness of birth control. Women who are taking birth control and are given a prescription for an antibiotic are strongly advised to use additional means of birth control during the entire monthly cycle for which the antibiotic has been used.

OTHER TREATMENT CHOICES: These include no treatment, waiting for more definite development of the symptoms or tooth or tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth and spread of infection to other areas. The risks of these alternative treatments are often more severe than those of root canal therapy.

CONSENT: I, the undersigned, being the patient (or legal guardian) consent to performing of the procedure decided to be necessary or advisable in the opinion of the doctor. I also understand that upon completion of root canal therapy in this office I shall return to my general family dentist for a permanent restoration of the tooth involved, such as a crown or a filling. I understand that root canal treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally, a tooth which has had root canal therapy, may require retreatment, corrective surgery or even extraction. I hereby state that I have read and understand this consent. This consent form does not encompass the entire discussion I had with the doctor regarding the treatment.

______________________________ Patient/Parent Signature

____________________ Date

Dr. Craig D. Pulsipher, DDS PA

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may 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.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.50 for each page, $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Tanya Turnovec

Telephone: (208) 734-7450 Fax: (208) 734-7484

E-mail: ____________

Address: 142 River Vista Place Twin Falls, ID 83301

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