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

Pulsipher Endodontics - Dr. Craig D. Pulsipher DDS

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 16, 2026 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they participate in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to perform their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

SUD Treatment Information. If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us.

In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already acted in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. 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 the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

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. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

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 if 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.

PRIVACY OFFICIAL NAME AND CONTACT INFORMATION:

Privacy Official: Tanya-Office Manger

Telephone: 208-734-7450 Email: info@twinfallsendo.com

Address: 142 River Vista Place Twin Falls, ID. 83301