PATIENT NAME ____DATE _________________________

PATIENT HIPPA QUESTIONNAIRE

Due to Health Insurance Portability and Accountability Act (HIPPA) of 1996, the following information is needed to authorize Dr. Kelly Blair and Dr. Jerry Scott to release any of my medical or dental insurance information necessary to process my insurance claims and coordinate or manage my dental care.

In the event a family member or caregiver attends your office visits, is in the exam room at the time of your evaluation and/or treatment, or needs to discuss your treatment at any given later date, I give permission to the above doctors and their team members to discuss freely my condition, treatment, or diagnosis with that person.

May we leave messages at the following places regarding your dental/medical health?

HOME #: ______________________________ YES / NO

CELL#: ______________________________ YES / NO

WORK#: ______________________________ YES / NO

OTHER#: ______________________________ YES / NO

With whom may we discuss or release information about your care, treatment, or diagnosis?

____ Relationship ______________________________

____ Relationship ______________________________

____ Relationship ______________________________

I give permission for office to contact my physician's ____

PRINT PATIENT NAME ____

PATIENT/GUARDIAN SIGNATURE ____ DATE __________________

(GUARDIAN IF UNDER 18 YRS)