(Facility’s Name)

(Facility’s Address)

(Facility’s Phone Number)

**MEDICAL QUESTIONNAIRE RELEASE FORM**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  | | --- | --- | --- | --- | | Client’s Name |  | Date |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | DOB |  | Age |  | Type of ID |  |  |  |  |  |  | | --- | --- | --- | --- | | Address |  | Phone Number | ( ) |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | City |  | State |  | Zip |  | |

Safe Body Art Act requires that prior to the performance of body art, the client shall receive, complete, and sign a questionnaire that includes all of the following information:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  | | --- | --- | --- | | |  | | --- | |  |   Initials | I am not pregnant. | | |  | | --- | |  |   Initials | I do not have a history of herpes infection at the proposed proceduresite. | | |  | | --- | |  |   Initials | I do not have allergic reactions to latex or antibiotics | | |  | | --- | |  |   Initials | I do not have diabetes. | | |  | | --- | |  |   Initials | I do not have hemophilia or other bleeding disorder, or cardiac valve disease. | | |  | | --- | |  |   Initials | I do not have a history of medication use and I am not currently using medication, including prescribed antibiotics prior to dental or surgical procedures. | | |  | | --- | |  |   Initials | I do not have other risk factors for bloodborne pathogen exposure. | |

All information gathered from the client that is personal medical information and that is subject to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or similar state laws shall be maintained or disposed of in compliance with those provisions.

(Facility’s Comments/Statements If Applicable)

|  |  |  |  |
| --- | --- | --- | --- |
| Signature |  | Date |  |