MEDICAL QUESTIONNAIRE RELEASE FORM

Facility Name:_____

Facility Address: _____

Facility Phone Number: _____

THIS SECTION TO BE COMPLETED BY CLIENT			
Name:			Date:
Date of Birth:	Age:	Type of Identification:	
Address:			City:
State:	Zip:	Phone Number:	

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

Please acknowledge each statement by writing your initials in the space provided.

Initials	Statement
	I am not pregnant.
	I do not have a history of herpes infection at the proposed procedure site.
	I do not have diabetes.
	I do not have allergic reactions to latex or antibiotics.
	I do not have hemophilia or other bleeding disorder or cardiac valve disease.
	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.
	I do not have other risk factors for bloodborne pathogen exposure.

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

Facility Statement if applicable:

Print Name:	
Signature:	Date: