



HALEY GOTTFRIED MANN, DDS
 JORDAN S. SCOTT, DMD
 CORY S. KUYK, DMD
 1415 PATTON AVE * ASHEVILLE, NC 28806
 Phone (828) 254-9692 * Fax (828) 259-9189
www.westashevilledentist.com

PLEASE PRINT

CONFIDENTIAL INFORMATION QUESTIONNAIRE

Patient's Legal name		Last	First	Middle Initial	Date OF Birth	Sex	SSN
Prefer to Be Called			Home Phone Number			Cell Phone Number	
Patient's Address		Street	Apt#	City	State/Zip	E-mail	
Marital Status		Patient's/Guardian's Employer				Occupation	
<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> Under age 18							
Work Address		Street	Apt#	City	State/Zip	Work Phone Number	
Spouse's Legal Name		Last	First	MI	Spouse's Employer		Occupation
Spouse's Work Address		Street	Apt#	City	State/Zip	Work Phone Number	
Other Family Members that are Patients Here					Who can we thank for referring you to our office?		

EMERGENCY CONTACT INFORMATION

Person we may contact in case of an emergency:

Name		Relationship
Home Phone Number	Work Phone Number	Cell Phone Number

REQUEST FOR CONFIDENTIAL COMMUNICATION

As my dental care provider, you may do the following with my Permission:

	YES	NO
Contact me at home	<input type="checkbox"/>	<input type="checkbox"/>
Contact me via cell phone	<input type="checkbox"/>	<input type="checkbox"/>
Contact me at work	<input type="checkbox"/>	<input type="checkbox"/>
Contact me via e-mail	<input type="checkbox"/>	<input type="checkbox"/>
Leave messages on my home voicemail/answering machine	<input type="checkbox"/>	<input type="checkbox"/>
Leave messages on my cell phone voicemail	<input type="checkbox"/>	<input type="checkbox"/>
Leave messages on my work voicemail/answering machine	<input type="checkbox"/>	<input type="checkbox"/>

INSURANCE AND FINANCIAL INFORMATION

Insurance Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Insurance Company Name	Insurance Address	Insurance Phone
Subscriber's Name	Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Subscriber's Birthday	Subscriber's SSN
Group/Program Number	Employer (If different from above)	Employer's Address	
Secondary Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient's/Guardian's Employer	Occupation	
Subscriber's name	Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Subscriber's Birthday	Subscriber's SSN
Group/Program Number	Employer (if different from above)	Employer's Address	

RELEASE INFORMATION

You may discuss my healthcare with:

	Others (Please Print)													
<table style="margin-left: auto; margin-right: auto;"> <tr> <td></td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> <tr> <td style="text-align: center;">Health Care Providers</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">Insurance Companies</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		YES	NO	Health Care Providers	<input type="checkbox"/>	<input type="checkbox"/>	Insurance Companies	<input type="checkbox"/>	<input type="checkbox"/>	<table style="width: 100%;"> <tr> <td style="width: 50%;">1.</td> <td style="width: 50%;"></td> </tr> <tr> <td>2.</td> <td></td> </tr> </table>	1.		2.	
	YES	NO												
Health Care Providers	<input type="checkbox"/>	<input type="checkbox"/>												
Insurance Companies	<input type="checkbox"/>	<input type="checkbox"/>												
1.														
2.														



confirmations

Do you prefer a confirmation call?

No, it is unnecessary Yes, it is a helpful reminder

ASSIGNMENT & RELEASE

I hereby authorize (1) any available insurance benefits to be paid directly to my dentist, (2) the release of my dental health care information for any of my dental health care insurance claims, (3) the use of my dental records by my dentist in any professional manner that he/she determines, (4) the making of videotapes, photographs, and x-rays of my dental care treatment (collectively "my images"), and (5) my dentist's use of my images in scientific papers, demonstrations and/or presentations without compensation to me. I agree that to the extent the cost of the dental care provided by my dentist is not covered by insurance, I am obligated to pay him/her such uninsured cost (the "uninsured costs") in accordance with his/her payment terms and policies. Finally, I certify that I have read or had read to me the contents of this form and understand the risks and limitations involved with the dental treatment that I am to receive.

Signature - Patient	Date
Witness Signature	Date
<p>If the above named patient is a minor or unable to pay the/his/her uninsured costs, the undersigned agrees to guaranty the payment of such uninsured costs to the patient's dentist in accordance with his/her payment terms and policies.</p>	
Signature - Guarantor of Patient	Date



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Medical History

Patient Name _____ Nickname _____ Age _____

Name of Physician and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD: (Please circle)	YES	NO	YES	NO
1. hospitalization for illness or injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic reaction to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine				
<input type="checkbox"/> penicillin				
<input type="checkbox"/> erythromycin				
<input type="checkbox"/> tetracycline				
<input type="checkbox"/> sulfa				
<input type="checkbox"/> local anesthetic				
<input type="checkbox"/> fluoride				
<input type="checkbox"/> metals (nickel, gold, silver, _____)				
<input type="checkbox"/> latex				
<input type="checkbox"/> other _____				
3. heart problems, or cardiac stent within the last six months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. history of infective endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. orthopedic implant (joint replacement)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. rheumatic or scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. high or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. a stroke (taking blood thinners)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. prolonged bleeding due to a slight cut (INR > 3.5)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. emphysema, shortness of breath, sarcoidosis, tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. measles, chicken pox.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. thyroid, parathyroid disease, or calcium deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. hormone deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. high cholesterol or taking statin drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. diabetes (HbA1c = _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. stomach or duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. digestive disorders (i.e. celiac disease, gastric reflux)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. osteoporosis/osteopenia (i.e. taking bisphosphonates)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. autoimmune disease (i.e. rheumatoid arthritis, lupus, scleroderma)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. head or neck injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. epilepsy, convulsions (seizures)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. neurologic disorders (ADD/ADHD, prion disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. viral infections and cold sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. any lumps or swelling in the mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. hives, skin rash, hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. STI / STD / HPV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. hepatitis (type _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. tumor, abnormal growth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. chemotherapy, immunosuppressive medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. emotional difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. psychiatric treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. antidepressant medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46. alcohol / recreational drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47. prostate disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOU:				
48. presently being treated for any other illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49. aware of a change in your health in the last 24 hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(i.e. fever, chills, new cough, or diarrhea)				
50. taking medication for weight management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51. taking dietary supplements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
52. often exhausted or fatigued	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
53. experiencing frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
54. a smoker, smoked previously or use smokeless tobacco.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
55. considered a touchy / sensitive person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
56. often unhappy or depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
57. taking birth control pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
58. currently pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

List all medications, supplements, and/or vitamins taken within the last two years.

DRUG	PURPOSE	DRUG	PURPOSE

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

DOCTOR'S SIGNATURE _____ DATE _____



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Dental History

Patient Name _____ Nickname _____ Age _____

Referred by: _____ How would you rate the condition of your mouth? Excellent Good Fair Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent treatment (other than a cleaning) ____/____/____

I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PERSONAL HISTORY

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had an unfavorable dental experience? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had complications from past dental treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had trouble getting numb or had any reactions to local anesthetic? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did you ever have braces, orthodontic treatment, or had your bite adjusted? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any teeth removed or missing teeth that never developed? | <input type="checkbox"/> | <input type="checkbox"/> |

GUM AND BONE

- | | | |
|---|--------------------------|--------------------------|
| 7. Do your gums bleed or are they painful when brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever been treated for gum disease or been told that you have bone loss around your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever noticed an unpleasant taste or odor in your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Is there anyone with a history of periodontal disease in your family? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever experienced gum recession? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |

TOOTH STRUCTURE

- | | | |
|--|--------------------------|--------------------------|
| 14. Have you had any cavities within the past 3 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? | | |
| 16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are any teeth sensitive to hot, cold, biting, or sweets? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you have grooves or notches on your teeth near the gum line? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you frequently get food caught between any teeth? | <input type="checkbox"/> | <input type="checkbox"/> |

BITE AND JAW JOINT

- | | | |
|--|--------------------------|--------------------------|
| 21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Are your teeth becoming more crooked, crowded, or overlapped? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Are your teeth developing spaces or becoming more loose? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you need to bite, squeeze, or shift your jaw to make your teeth fit together? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do you place your tongue between your teeth or close your teeth against your tongue? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Do you clench your teeth in the daytime or make them sore? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Do you wear or have you ever worn a bite appliance? | <input type="checkbox"/> | <input type="checkbox"/> |

SMILE CHARACTERISTICS

- | | | |
|---|--------------------------|--------------------------|
| 33. Is there anything about the appearance of your teeth that you would like to change? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Have you ever whitened (bleached) your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you felt uncomfortable or self conscious about the appearance of your teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Have you been disappointed with the appearance of previous dental work? | <input type="checkbox"/> | <input type="checkbox"/> |

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

DOCTOR'S SIGNATURE _____ DATE _____



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TREATMENT CONSENT FORM

I, _____, consent to be a patient at the above named office and agree to a radiographic and clinical examination. I also understand and consent to the following:

1. During the course of treatment, I could possibly undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.
2. I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.
3. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.
4. I will pay in full any cost of treatment or insurance copayments according to the office's financial policy. I understand that even if an insurance pre-estimate is given or a procedure has been preapproved, I am responsible for any costs that my insurance does not cover.
5. My treatment plan may change at any time due to unforeseen circumstances and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.
6. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

Patient/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____



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PAYMENT POLICY AGREEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we ask that you read and sign prior to any treatment. We accept Cash, Checks, Visa, MasterCard, Discover & American Express Cards.

For those patients who DO NOT HAVE DENTAL INSURANCE, payment in full is expected for services rendered on the day of service.

INSURANCE

If the patient or responsible party has an Insurance plan, the office will produce and send claims to the insurance carrier the same day of service, provided evidence of benefits (Insurance Card/Completed and Signed Form) is presented to the office. **ANY ESTIMATED PORTION OF SERVICES NOT COVERED BY INSURANCE IS DUE ON THE DAY SERVICES ARE RENDERED.**

Your Insurance Policy is a contract between you and your insurance company. We file your insurance and accept assignment of benefits as a courtesy to you, our valued patient. If your insurance company has not paid for your claim within 60 days, you are responsible for payment of the balance at that time. We will be happy to provide necessary documentation to your insurance company so that you may call them to discuss the non-payment of your claim, but we require payment from you for the account balance.

Our Practice is committed to providing the BEST TREATMENT for our patients, and our fees are reasonable for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of "Usual and Customary" rates or for alternate treatment substitute determination. "Usual and Customary" fees vary widely between different Insurance Plans.

MISSED APPOINTMENTS

In order to ensure we have appointments available for our patients we must have 24-hour notice if you must cancel a scheduled appointment. Repeated missed appointments without notice will result in dismissal from our practice. Please help us serve you better by keeping scheduled appointments.

Patient Signature _____ Date: _____
or Responsible Party _____



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received/been
offered a copy of this office's Notice of Privacy Practices.

Print Name: _____

Patient Signature/Guardian: _____

Date: _____

.....
FOR 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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other: _____



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AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient: _____ Date of Birth: _____

The office of Drs. Mann, Scott, & Kuyk is authorized to release protected health information about the above named patient to the entities named below.

Entity to Receive Information Check each person/entity that may receive information.	Description of Information to be Released Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays <input type="checkbox"/> Other: _____
<input type="checkbox"/> Spouse (provide name)	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____
<input type="checkbox"/> Parent (provide name)	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____
<input type="checkbox"/> Other (provide name)	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____

PATIENT INFORMATION:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

I understand that the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by patient.

Patient Signature
or Personal Representative _____ Date: _____