Alliance Oral & Maxillofacial Surgery, P.A.

David Parmer, DDS MD James Macholl, DDS MD

Due to Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be filled out by each patient annually.

DATE: _____

I authorize Associates In Oral & Maxillofacial Surgery, to release any of my medical or insurance information necessary to process my medical claims and coordinate or manage my health care.

In the event a family member or caregiver attends your office visit and is in the exam room at the time of your evaluation, I give Associates In Oral & Maxillofacial Surgery and it's physicians or employees my permission to discuss freely my condition, treatment, or diagnosis with that person. YES / NO

HOME PHONE: _____MAY WE LEAVE A MESSAGE: YES/NO

WORK PHONE: _____MAY WE LEAVE A MESSAGE: YES/NO

CELL PHONE: _____MAY WE LEAVE A MESSAGE: YES/NO

May we leave a message at one of the numbers listed above about your appointments?
YES / NO HOME / WORK / CELL

May we call your name out loud in our lobby? YES / NO

With whom may we discuss or release information about your care and treatment?
_____Relationship_____

_____Relationship_____

With whom may we not discuss or release any information about your care and treatment?
_____Relationship_____

Signature: _____
(Signature is valid one year from date shown above)

Printed Name: _____