Periodontics & Implants
Mark Kolozenski, DDS, MS

General Information

Patient Name_____Preferred Name_____

Date of Birth_____SS# _____Marital Status: M S D W

Address_____City_____State_____ZIP_____

Cell#_____Home#_____Work#_____

Email_____Occupation_____

Employer_____Employer Address_____

Responsible Party (If Minor)_____Relationship_____

Address (If Other Than Patient)_____

Emergency Contact_____Relationship_____Phone#_____

Insurance Information

(You may skip this section if you provided a copy of your Insurance Card)

Primary Insurance Company_____Phone #_____

Member/Subscriber ID#_____Group#_____

Policy Holder (If Other Than Patient)_____Relationship_____

SS #_____Date of Birth_____Phone#_____

Secondary Insurance Company_____Phone #_____

Member/Subscriber ID#_____Group#_____

Policy Holder (If Other Than Patient)_____Relationship_____

SS #_____Date of Birth_____Phone#_____

Additional Information

Who can we thank for referring you to our practice?_____

General Dentist_____Phone#_____

Pharmacy_____Phone#_____Location_____

HIPAA Acknowledgement

I understand that I may inspect or request a copy of the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

PLEASE COMPLETE:

☐ I do NOT give permission to anyone.

☐ I give permission for the following individuals (husband/wife, friend, etc.) to access my personal information: _____

SIGNATURE_____DATE_____