JACKSON
IMPLANTS & PERIODONTICS

Amar Katranji, D.D.S., M.S.
Kelly Misch, D.D.S., M.S.
Julius Bunek, D.D.S., M.S.
Diplomates, American Board of Periodontology

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE POLICY

I acknowledge that I received a copy and read through the Notice of Privacy Practices for Jackson Implants & Periodontics, PLC.

Patient Name: _____ Date: _____

Signature: _____

I AUTHORIZE AND CONSENT THAT THE FOLLOWING INDIVIDUALS MAY BE INFORMED OF MY PERIODONTAL STATUS AND/OR TREATMENT RENDERED

I _____, WILL ALLOW Jackson Implants & Periodontics, PLC to discuss my periodontal treatment or diagnosis with the following individuals listed below. An example would be a spouse or significant other, a family member, or friend who may be driving you home from treatment.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

721 17th St.
Jackson, MI 49203
www.miimplants.com

(517) 782-3607
jacksonmip2018@gmail.com