TRIO-DENT Klinika Stomatologiczna Ponad 20 lat doświadczenia!

1.1. I authorize the following persons to **receiving information** about my health and benefits provided to me:

No.	Authorized person	Address

□ **1.2** I do not authorize anyone to receive information about my health and benefits provided to me

□ **2.1** I authorize the following persons to **obtain medical records** concerning my person

No.	Authorized person	Address

□ **2.2** I do not authorize anyone to obtain medical records regarding my person

Date of submitting the statement: .....

Patient's Signature.....

ul. Polna 3 Warsaw,
tel./fax: 826 20 64
www.triodent.com.pl

TRIO-DENT Klinika Stomatologiczna Ponad 20 lat doświadczenia!

Welcome to Specjalistyczna Klinika Stomatologiczna TRIO-DENT in Warsaw.

We kindly ask you to answer the questions below. Filling in the questionnaire will enable you and your doctor to quickly and systematically collect relevant information. This is necessary to obtain the best cooperation between dentists of various specialties conducting your treatment. It is also important to get acquainted with your general health condition, because both the accompanying and past diseases, age and lifestyle have impact on the course of treatment and its effects. All information provided by you is covered by medical secrecy and is available only to the medical personnel involved in the treatment. We are required to collect and store personal data in accordance with the Ordinance of the Minister of Health of July 30, 2001 (Journal of Laws 01.83.903 of August 13, 2001) and the Act of August 29, 1997 on the Protection of Personal Data (Journal of Laws of 2002 No. 101, item 926). Any information obtained will only be used to keep medical records in accordance with the applicable regulations.

.....
PATIENT'S FIRST AND LAST NAME

.....
ADDRESS OF RESIDENCE (street, postal code, city)

Personal Identification Number (PESEL)/DATE OF BIRTH

....
CONTACT TELEPHONE EMAIL ADDRESS

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