Dr. TOM WIERZBICKI
DDS FRCD(C)
PERIODONTICS & DENTAL IMPLANTS

Date: _____

Patient Contact

Name: _____
First Middle Last

Birth Date :_____ Gender:_____

Address:_____
Suite/Apt Street City Province Postal Code

Email:_____

Home Number:_____ Cell Number:_____ Other:_____

By what method do you prefer our office to contact you ?(Please circle)
Home Phone Mobile phone Text Email

Consent For Release of Information to Dental Insurance Provider

I, _____ (PRINT NAME), authorize release, to my dental benefits plan administrator and the Canadian Dental Association (CDA), information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.

Signature of person authorizing release: _____

Medical History

The following information is required to provide you with the best dental care. All information is confidential.The dentist will review the questions and explain any that you do not understand. Please complete the entire form.

1) Do you have regular check-ups with your family doctor? **YES NO**

Name of Physician: _____

Telephone# :_____

2) Do you take any medications , non-prescription drugs or herbal supplements? **YES NO**

If yes , please list them all:

3) Have you ever or are you currently taking any oral medications(e.g Etidronate(Didrocal), Alendronate(Fosamax) , Risedonate(Actonel) or any IV medications (e.g Zoledronicacid(Reclast) or Ibandronate(Bonita) for your bones including for osteoporosis, bone pain, Hypercalcemia, Paget's disease, multiple Myeloma or Metastatic cancer? **YES NO**

4) Have you ever have had an abnormal reaction to any medications or injections? **YES NO**

5) Have you ever had an abnormal reaction to anesthetic or general anesthetic? **YES NO**

6) Have you ever been advised by a doctor/dentist to take antibiotics before dental treatment? **YES NO**

7) Have you ever been hospitalized for any illness or operation? **YES NO**

If yes, please list them all:

8) Do you have any allergies? **YES NO**

If yes, please list them all:

9) Do you, or have you had in the past, any of the following? (Please circle)

Alcohol dependency	Diabetes	Irritable bowl syndrome	Rheumatic fever
Anemia	Drug dependency	Kidney disease	Seizures (epilepsy)
Arthritis	Fainting spells	Leukaemia	Shortness of breath
Artificial joints	Gastric reflux (GERD)	Liver disease	Sickle cell disease
Artificial heart valve	Heart attack	Organ transplant	Sleep apnea
Bleeding disorders	Heart disease	Osteoporosis	Steroid therapy
Cancer	Heart murmur	Pacemaker	Stomach ulcers
Chemotherapy	Hemophilia	Radiation therapy	Thyroid disease
Chest pain (Angina)	High blood pressure	Removal of spleen	Tuberculosis

10) Do you, or have you in the past, any conditions or diseases not listed above? **YES** **NO**

If yes, please list them all:

11) Are there any medical conditions that run in your family (e.g diabetes, heart disease)? **YES** **NO**

If yes, please list them all :

12) Please provide your **Height:**_____**cm** **Weight:**_____**kg**

13) Do you smoke or use tobacco / cannabis products? **YES** **NO**

If yes, specify amount used for each:

Cigarettes _____ pack per day
Cigars _____ per per day
Vaporizer _____ times per day and E-Liquid strength _____ mg/mL
Pipe _____ times per day
Cannabis _____ grams/day

14) How long have you been using tobacco / cannabis products? _____ months/years

15) Is there a history of early tooth loss in your family? **YES** **NO**

16) Are you nervous about dental treatment? **YES** **NO**

If yes, please indicate on scale below.

(Not nervous) 1_____**10 (Very nervous)**

For Women only

17) Are you pregnant or suspect that you may be pregnant? **YES** **NO**

18) Are you nursing? **YES** **NO**

Use and Transfer of Clinical Images Consent

I give consent for clinical images (photographs and x-rays) to be taken of me, or of my child, or of a person for whom I am a legal guardian. I understand clinic images form part of my dental record. I understand that duplicates may be sent to the referring dentist/physician, as part of my treatment. At times, additional consolation/interpretation of the images may be required as part of my treatment. In such circumstances, Dr. Tom Wierzbicki will be required to send off the images, and relevant demographic and medical information to a third party health care provider (e.g. radiologist) for consultation. The images may be transferred by hard copy (e.g. CD) sent by mail, or electronic submission over the internet.

Furthermore, I understand that the clinical images, with my consent, may be used for the purposes of dental/medical training, research, teaching, publication in dental/medical textbooks or journals, or used for marketing of the clinic. I understand that if used for these purposes, the images will not contain any identifying information such as my name, but that it may still be possible that someone recognize me.

I acknowledge that I will not receive compensation for the use of the clinical images.

I understand that I have the right to withdraw consent at any time by written request to Dr. Tom Wierzbicki or West Calgary Periodontics staff.

I understand that refusal to consent to the use of clinical images will in no way affect the dental care I receive.

Please check Yes or No below to show type of consent given:

	YES / NO
Transfer to third party health care provider for consultation/interpretation	____ / ____
For education, research, and teaching purposes	____ / ____
In paper or electronic health publications (e.g. dental journals)	____ / ____
In marketing materials (e.g. patient pamphlets, website)	____ / ____

By signing below, I confirm that I understand this consent form, and had any questions related to it answered to my satisfaction.

_____ _____

Signature of Patient/Parent or Guardian Date