Sari Novack D.D.S.
Family and Cosmetic Dentist

4211 Yonge Street, Suite 201
Toronto, ON M2P 2A9
Tel: 416-224-2114 Fax: 416-224-1282

All data on this questionnaire will be kept confidential. The information requested is essential for your protection and ensures your treatment will be provided in the safest manner possible. We would appreciate your cooperation in filling out these forms carefully.

General Information

Today's Date: _____
Title: ❍ Dr. ❍ Mr. ❍ Mrs. ❍ Ms. Name: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____
Address: _____ Apt: _____
City: _____ Postal Code: _____
Marital Status: _____ Sex: _____ Date of Birth (mm/dd/yy): _____
Occupation: _____ Employer (Supervisor Name/Company): _____
Employer (Full Mailing Address): _____
In the case of Emergency contact: _____ Phone #: _____
If patient is a minor, who is legally responsible? _____
Whom may we thank for referring you to our office? _____
How do you want us to remind you about your appointment? (Please Circle) Home # Work # Cell # Email

Medical Information

Name of Family Doctor: _____ Phone #: _____
When was your last complete physical examination? _____
Are you now or within the last year under treatment by a Physician? No❍☐ Yes☐
Explain: _____
Have you had major surgery/operation or hospitalizations? No☐ Yes☐
Explain: _____
Are you taking any medications regularly? No☐ Yes☐
Explain: _____
Is there any history of family disease? No☐ Yes☐ Explain: _____
Do you smoke? No☐ Yes☐ # of cigarettes/packs per day? _____
Have you ever had any unusual or allergic reaction to any of the following drugs? (Please circle)

Penicillin	Sulpha	Eryhthromycin	Clindamycin	Seasonal Allergies/ Hay Fever
Local Anesthetics	Latex	Aspirin	Food Allergies (What: _____)	
Ibuprofen (Advil)	Codeine	Cortisol	Other: _____	

Do you have or have you had? (Check boxes)

❍ HIV/AIDS	❍ Congenital Heart Defect	❍ Kidney Disorder	❍ Bisphoshonate Medication
❍ High Blood Pressure	❍ Stroke	❍ Glaucoma	
❍ Heart Murmurs	❍ Artificial Joints	❍ Artificial Joints	❍ Herpes
❍ Shortness of Breath	❍ Blood Disorders	❍ Tuberculosis	❍ Veneral Disease
❍ Sinus Problems	❍ Anemia	❍ Thyroid Disease	❍ Stomach Ulcer
❍ Heart Trouble/ Attack	❍ Asthma	❍ Cancer	❍ Drug Dependency
❍ Swollen Ankles	❍ Breathing Problems	❍ Chemotherapy	❍ Nervous Disorders
❍ Heart Disease	❍ Prolonged Bleeding	❍ Radiation Therapy	❍ Psychiatric Care
❍ Angina/ Chest Pain	❍ Diabetes	❍ Epilepsy	❍ Malignant Hyperthermia
❍ Fainting Spells	❍ Liver Disorder	❍ Rheumatic Fever	❍ Organ Transplant
❍ Artificial Heart Valves	❍ Jaundice	❍ Jaundice	
❍ Pacemaker	❍ Hepatitis (A/ B/ C)	❍ Arthritis	

Is there anything about your physical condition that the doctor should know? No☐ Yes☐
Explain: _____
*** For Women*** Are you pregnant? No☐ Yes☐ In my _____month. # of Pregnancies _____**

Dental History and Information

Purpose of today's visit? _____
What are your immediate dental concerns? _____
What are long term dental goals? _____
When was your last dental check up? _____
Name of Previous Dentist: _____ Dentist's Phone #: _____
What motivated you to switch dentists? _____
Have you ever been seen by a dental specialist? No ☐ Yes ☐ Please specify specialty: _____
Have you ever been seen by a Periodontist (gum specialist)? No ☐ Yes ☐ If Yes how long ago? _____
Have you ever had Orthodontic treatment (braces)? No ☐ Yes ☐ If Yes how long ago? _____
Are you nervous during dental treatment (circle one)? Not Nervous- 1 2 3 4 5 6 7 8 9 10-Very Nervous

Are you familiar with the term "Periodontal Maintenance Care ? No ☐ Yes ☐
How often do you brush your teeth? Once a day ☐ Twice a day ☐ Three times a day ☐
What type of brush do you use? Manual ☐ Electric ☐ What type of bristle? Soft ☐ Medium ☐ Hard ☐
Do you clean between your teeth? No ☐ Yes ☐
If yes, what do you use? Floss ☐ Stimulator ☐ Water Pic ☐ Proxa-brush ☐ Toothpick ☐ Other ☐ _____

Do you have any of the following cause tooth discomfort? Hot ☐ Cold ☐ Sweets ☐ Chewing ☐
How do you feel about the appearance of your smile? _____
Have you ever suffered head, neck or back trauma? No ☐ Yes ☐ Please specify: _____
Do your jaws ever feel tired? No ☐ Yes ☐ Do your jaws ever: Click ☐ Pop ☐ Hurt ☐

Do you currently experience?

❍ Loose teeth	❍ Stained/ Discolored Teeth	❍ Bad Breath
❍ Missing Teeth	❍ Gagging	❍ Receding Gums
❍ Spaced or Crooked Teeth	❍ Food catching between your teeth	❍ Bleeding Gums
❍ Bite Changes	❍ Swelling(s)	❍ Frequent headache

Please number your expectations for dental treatment in order of importance (1- most important, 10- least important)

Relief of pain _____	Control clenching/grinding _____	Control gum disease _____
Straighten teeth _____	Replace missing teeth/Implant_____	Save remaining teeth _____
Restore health to gums _____	Improve appearance _____	Other: _____

Dental Insurance Information

Dental Insurance: No ☐ Yes ☐ Insurance Company Name: _____
Insured Name: _____ Insured D.O.B. (mm/dd/yy) _____
Insured Relationship (Please Circle): Self Spouse Child Common-law
Group/Plan #: _____ Certificate/I.D. #: _____
Employer: _____

I, _____Release Consent regarding information contained on this form to members of the Health professionals involved in my care.

I, authorize release, to my dental benefit plan administrator, information contained in claims submitted electronically. By signing this consent form, I, the above hereby entitle Dr. Novack and respective office staff to electronically submit my dental insurance claims to my insurance carrier via EDI submissions. Dr. Novack does not accept assignment. I therefore agree to pay Dr. Novack directly when any services are provided. I the insured will be receiving the insurance payment directly.

This is to certify that I, the undersigned, have read the forgoing and consent to undergo the dental procedures agreed to be necessary or advisable. I will assume responsibility for fees associated with those procedures.

I understand that 2 business days are required to cancel or re-schedule my dental appointment, otherwise a fee will be incurred.

Signature: _____ Date: _____