I have read the "Office Policy for the Collection, Use and Disclosure of Personal Information" of Dr. Allyson Bourke and her team. I acknowledge and agree that they can collect, use and disclose personal information about me and/or my child for the purposes listed.

Smiles In Motion

Welcome

ADULT PATIENT INFORMATION

Name _____ Birth date (D/M/Y) _____ Age_____
Address _____
Home Telephone _____ Business Telephone _____
Cell Telephone _____
Employer _____ Occupation _____
Orthodontic Insurance (Yes) _____ (No) _____

Dentist's Name _____ Physician's Name_____
Referred By (Dentist) _____ (Other) _____

MEDICAL INFORMATION

Have tonsils and/or adenoids been removed? _____Tonsils _____ Adenoids At what age? _____
Do you have any history of: ____asthma ___allergies ___chronic nasal obstruction?
Are you taking any prescribed medication? (Yes/No) specify_____
Is there any history or presence of?

___ birth defects
___ drug allergy/reaction
___ facial accidents
___ HIV +/aids
___ latex allergy
___ bleeding disorders
___ epilepsy
___ hepatitis A or B
___ kidney disease
___ learning disabilities
___ diabetes
___ emotional disorder
___ high/low blood pressure
___ liver disease
___ rheumatic fever

Please specify or comment on above: _____

ORTHODONTIC INFORMATION

Reason for orthodontic consultation or primary concern:_____
Are you self-conscious of your teeth or facial appearance? _____ (Yes) _____ (No)
Have you had any previous orthodontic experience? (Yes/No) specify _____
Is there anyone else in the family with similar orthodontic problems? _____
Has anyone else in the family had orthodontic experiences? _____
Have any teeth been heavily restored (crowns, bridges, root canal treatments)? _____ (Yes) _____ (No)
Indicate which of the following habits you have (Y) or have exhibited in the past (P):

___ thumb or finger sucking
___ snoring
___ speech difficulty
___ mouth breathing (day & night / night only)
___ tongue thrusting
___ lip biting
___ speech therapy
___ tooth grinding
___ nail biting
___ difficulty chewing

Any history of jaw joint problems: clicking, popping, pain, headaches, ringing in the ear? _____ (Yes) _____(No)
Please specify which symptom(s) onset/duration/severity _____
Brushing habits: _____ good _____ moderate _____ poor
Frequency of flossing: _____ daily _____ weekly _____ monthly _____ never
Are any teeth missing or have any teeth been extracted? _____ (Yes) _____ (No)

Please sign _____