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

CHILD PATIENT INFORMATION

Name _____ Birth date (D/M/Y) _____
Address (street/city/postal) _____
Telephone_____ Age ____ Grade_____ Gender (M)_____ (F)_____
Sibling Rank ____ Ages of brothers _____ Ages of sisters _____
Dentist's Name_____ Referred By (Dentist) ____(Other)_____

RESPONSIBLE PARTY

Father's Name _____ Home Telephone _____
Address _____
Employer _____ Business Telephone _____
Occupation _____ Orthodontic Insurance (Yes) _____ (No) _____

Mother's Name _____ Home Telephone _____
Address _____
Employer _____ Business Telephone _____
Occupation _____ Orthodontic Insurance (Yes) _____ (No) _____

Person responsible for the orthodontic account: _____ (father) _____ (mother) _____(other, specify) _____

MEDICAL INFORMATION

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

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

Please specify or comment on above: _____
_____

ORTHODONTIC INFORMATION

Reason for orthodontic consultation or primary concern:_____
Is the patient self conscious of his/her teeth? (Yes/No)
Has the patient 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 of the permanent teeth been chipped or injured? _____ (Yes) _____ (No)
Indicate which of the following habits the patient has (Y) or has exhibited in the past (P):

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

Any history of jaw joint problems: clicking, popping, pain, headaches, ringing in the ear? _____ (Yes) _____(No)
Brushing habits _____ good _____ moderate _____ poor
Intake of sweets _____ high _____ moderate _____ low
Would the patient object to wearing braces if they are indicated to do so? _____ (Yes) _____(No)

Responsible Party who completed this form- Please sign _____