STEVEN J. LUCCARELLI, D.D.S.
JOSEPH BARRESE, D.D.S
Practice Limited to Orthodontics

PATIENT'S INFORMATION

Patient's Name | Date of Birth | Age

Home Address | Sex F M

Home Phone | Alternate Phone

Spouse's Name | Email Address

Person Responsible for Account | Relationship to Patient

Address

Home Phone

Employer | Work Phone | Ext.

Work Address

Insurance that may cover any part of service

MEDICAL CONTACT INFORMATION

Patient's Dentist

Dentist's Address

Date of Last Dental Visit | Were X-Rays Taken?

Physician | Physician's Address

Who can we thank for referring you to our office?

MEDICAL HISTORY

General Medical History

Has the patient had any of the following medical problems?

Y	N	Allergic to Plastic	Y	N	Convulsions/ Epilepsy	Y	N	Allergic to Latex/ Metals
Y	N	Asthma	Y	N	Hearing Impairment	Y	N	Congenital Heart Defect
Y	N	Cancer				Y	N	Heart Murmur or Aliment

Y N Has pre-medication been necessary for dental visits?
Y N Are you taking any Bisphosphonates? (Eg. for Osteoporosis such as Fosamax)

Please describe any current medical treatment and list all medications currently taking:

Dental History

Does the patient have any of the following habits?

Y	N	Have there been any injuries to the face, mouth or teeth?	Y	N	Are any musical wind instruments played
Y	N	Are there any speech problems?	Y	N	Has an Orthodontist been previously consulted?
Y	N	Are you a mouth breather?	Y	N	Would you mind wearing braces?
Y	N	Have you been informed of any impacted teeth?	Y	N	Have any other members of the family worn braces?
Y	N	Have you been informed of any missing, or extra teeth?			

In your own words, what is the problem?