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

CHILD'S INFORMATION

Child's Name

Date of Birth | Age | Sex M F

Home Address

Home Phone | Alternate Phone

School / Year | Email Address

PARENT / GUARDIAN INFORMATION

Parent / Guardian | Spouse's Name

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

Child's Dentist

Dentist's Address

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

Physician | Physician's Address

Referred By

MEDICAL HISTORY

General Medical History

Has your child 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?

Please list any current medical treatment and list all medications your child is currently taking:

DOES YOUR CHILD HAVE SENSORY ISSUES OR ANY OTHER SPECIAL NEEDS THAT WE SHOULD BE AWARE OF?

DENTAL HISTORY

Does your child 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	Is (s)he a mouth breather?	Y	N	Have any baby teeth been removed?
Y	N	Does (s)he suck on thumb or fingers?	Y	N	Would (s)he 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?