Grand Ridge Orthodontics

John F. Monticello DDS, MS
(616)-364-1700

Initial Exam Date _____
_____

Patient Name _____ _____ _____ _____ Phone(____)_____
First Middle Last Nickname

Address _____ Birthday _____ __

City & State _____ Zip _____ Age _____ Sex _____

Father or Self or Guardian Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home ph#: _____ Work ph#: _____

Cell ph# _____

Birthdate: _____ Age: _____ Sex: _____

Marital Status: _____ S.S. #: _____

How long at this address? _____

Email address: _____

Employer/Insurance Information

Employer Name: _____

Occupation: _____

Employer Address: _____

Employer City: _____ State: _____ Zip: _____

Number of yrs employed: _____ Title: _____

Insurance Company: _____

Insurance Address: _____

Insurance City: _____ State: _____ Zip: _____

Insurance Phone #: _____

Group ID#: _____ Local or Union #: _____

Orthodontic Coverage: YES NO

Mother or Spouse or Guardian Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home ph#: _____ Work ph#: _____

Cell ph#: _____

Birthdate: _____ Age: _____ Sex: _____

Marital Status: _____ S.S. #: _____

How long at this address? _____

Email address: _____

Employer/Insurance Information

Employer Name: _____

Occupation: _____

Employer Address: _____

Employer City: _____ State: _____ Zip: _____

Number of yrs employed: _____ Title: _____

Insurance Company: _____

Insurance Address: _____

Insurance City: _____ State: _____ Zip: _____

Insurance Phone #: _____

Group ID#: _____ Local or Union #: _____

Orthodontic Coverage: YES NO

Who is responsible party: _____

Dentist Name? _____

Address: _____ Ph#: _____

Physician Name: _____

Address: _____ Ph#: _____

Who may we thank for referring you: _____

Sports or Hobbies: _____

School Name: _____ Grade: _____

Number of Brothers: _____ Ages: _____

Number of Sisters: _____ Ages:

1750 Grand Ridge Ct. NE, Ste 300 Grand Rapids, MI 49525

"For the Smile that lasts a Lifetime"

www.grandridgeorthodontics.com

MEDICAL INFORMATION

YES	NO		YES	NO		YES	NO	
☐	☐	Frequent or Severe Headaches	☐	☐	Is Patient under Medical Care	☐	☐	Hepatitis
☐	☐	Any Heart Disease	☐	☐	Rheumatism or Arthritis	☐	☐	Polio
☐	☐	Any Sinus or Respiratory Disease	☐	☐	Is the Patient taking any Medication	☐	☐	Diabetes
☐	☐	Any Blood Disease	☐	☐	Any History of Fainting or Dizziness	☐	☐	Anemia
☐	☐	Any Liver Disease	☐	☐	Does the Patient have a Drug Addiction	☐	☐	Hemophilia
☐	☐	Any Thyroid Disease	☐	☐	Is the Patient Pregnant at this time	☐	☐	Emphysema
☐	☐	Any Kidney Disease	☐	☐	Measles/Mumps/Chicken Pox	☐	☐	Epilepsy
☐	☐	H.I.V. Positive	☐	☐	Does the Patient Smoke	☐	☐	Asthma or Hay Fever
☐	☐	Any Venereal Disease	☐	☐	Has the Patient ever had Fever Blisters	☐	☐	Tuberculosis
☐	☐	Any Intestinal Disease	☐	☐	Is Height & Weight Normal for Age	☐	☐	Any Broken Bones
☐	☐	Any Bone Disease	☐	☐	Is the Patient in Good Health	☐	☐	Prolonged Bleeding
☐	☐	Any Nervous/Emotional Problems	☐	☐	Has the Patient had a Physical this Year	☐	☐	Yellow Jaundice
☐	☐	Any High or Low Blood Pressure	☐	☐	Has the Patient reached Puberty	☐	☐	Radiation Therapy
☐	☐	Any Endocrine Problems	☐	☐	If Male, begun to Shave	☐	☐	Chemical Therapy
☐	☐	Any Problems with Wounds Healing	☐	☐	If Female, begun to Menstruate	☐	☐	Blood Transfusions
☐	☐	Any Tumors or Cancer	☐	☐	Heart Murmur	☐	☐	Latex Allergy
☐	☐	Tonsilitis/Frequent Sore Throat						
☐	☐	Any Joint Problems	☐	☐	Is the Patient Allergic to Anything?, If **YES,** What:_____			
☐	☐	Rheumatic/Yellow/Scarlet Fever	☐	☐	Are you aware of any other disease, condition or problem not listed above that we should know about? If **YES,** What: _____			
☐	☐	Acquired Immune Deficiency Syndrome						
			☐	☐	Any Unusual Reactions to Any of the Following: Aspirin:_____ Penicillin: _____ Sulfa Drug: _____ Barbiturates:_____ Other Medications:_____			

List Any Medications Currently Taking_____ Please Explain_____

_____

DENTAL HISTORY

YES	NO		YES	NO		YES	NO	
					Does the Patient Have or Ever Had Any of the Following Habits			
☐	☐	Has the Patient seen a General Dentist in the last year	☐	☐	Cheek/Tongue or Lip Chewing	☐	☐	Clenching Teeth
☐	☐	Any Pain, Clicking or Discomfort in or near the Ears	☐	☐	Thumb Sucking	☐	☐	Tongue Thrusting
☐	☐	Mouth, Face or Teeth Been Injured by a Fall or Accident	☐	☐	Mouth Breathing	☐	☐	Grind Teeth
☐	☐	Have You Been informed of Missing or Extra Permanent Teeth	☐	☐	Finger Nail Biting	☐	☐	Speech Problems
☐	☐	Are You aware of Any Gum Problems	☐	☐	Has the Patient Been Examined by an Orthodontist Before			
☐	☐	Have the Patients Tonsils or Adenoids been removed			If Yes, When _____			
☐	☐	Do You feel the Patient can Benefit from Orthodontic Treatment	☐	☐	Have other family members had Orthodontic Treatment Before			
☐	☐	Is the Patient Happy with their "SMILE"	☐	☐	If Yes, Were you Happy with the Results			
☐	☐	Does the Patient Want to Improve their "SMILE' and "BITE			If No, Why_____			

In your own words, what is the Orthodontic Problem_____

What would you like Orthodontic Treatment to Accomplish_____

If you choose to finance through our office, we reserve the right to inquire into your credit history.

_____ _____ _____

Patient Signature **Date** **Parent Signature**

FOR OFFICE USE ONLY

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